ARCHIVES OF SURGERY.

OCTOBER, 1890.

BIRMINGHAM AND BERLIN.

NOTES FROM THE TWO CONGRESSES.

The Annual Meeting of the British Medical Association was held this year at Birmingham, and in the following week the tenth Triennial International Congress of Physicians and Surgeons took place at Berlin. I was present at both, and both were occasions of great professional interest. I purpose in the following pages to mention briefly some of the subjects which chiefly claimed my attention. I must premise that my notes will be for the most part personal, and that I do not in the least profess to try to select what was really of most importance. This has already been ably done by others. I shall record only what fell under my own observation, and speak chiefly of things in which I had some share. To attempt more would be foreign to the proposed scope of my Archives.

The Annual Museum at the Birmingham Meeting was not fortunate in the rooms allotted to it. They were ill-lighted and too small, and, further, the best space was given up to tradesmen who had hired it. Surgical instrument makers, druggists, medical booksellers, and purveyors of patent foods, were well represented, but pathology and other more strictly professional subjects were somewhat pushed aside. Notwithstanding these disadvantages, however, there was much to be learnt if you cared to take trouble and seek for it. It was

needful, however, to seek very diligently and make many inquiries, or you might miss all the best things.

Mr. Oliver Pemberton exhibited, in two large folio volumes, a very valuable collection of drawings, some of them beautifully done. They illustrated most various subjects in relation to surgery and pathological anatomy, and some of them were well worthy of being reproduced.

From the Museum of Queen's College (Birmingham) a large number of the more important specimens had been judiciously selected, and were specially described in the catalogue.* This department of the Annual Museum is always a very useful one, and it is easily attended to by the local committee. It saves visitors a great deal of trouble to have selections of the best things made from the local museums, since they thereby escape the necessity of searching through the latter for themselves. Local exhibits, whether from public or private collections, ought indeed to constitute the principal part of the Annual Museum, for it is both expensive and very troublesome to send such things from a distance. I may here remark as regards objects from distant places, that drawings constitute by much the most convenient material for this purpose. I never visit an Annual Museum without regret that so few of these are usually shown. It is impossible without much risk of damage to send wax models or wet preparations, but a portfolio of drawings will travel easily and receive but little hurt.

Amongst the more interesting of the objects contributed from the Birmingham Museums were a series of examples of rare forms of disease of the heart and blood vessels, and another (chiefly obtained from operations by Mr. Lawson Tait) illustrating various forms of Ectopic gestation.

In the department of anatomy and physiology, Professor Cunningham's series of beautiful models, illustrative of cranio-cerebral topography and brain growth, were to be seen, and others of scarcely less interest by Dr. J. John Brooks, Professor Birmingham of Dublin, and others. Dr. Ernest Jacob, of Leeds, had some interesting specimens and drawings,

* This series had been arranged by Mr. Gilbert Barling, Dr. G. F. Crooke, and Dr. C. Martin, from the Pathological Museum of the College.

amongst the latter one of "advancing lymphangioma of the tongue." The disease was believed to have been congenital. Dr. Jacob brought some casts illustrating changes in the nutrition of the digits allied to Raynaud's disease, sclerodermia, and "last joint arthritis."

Renal and vesical calculi, tumours of the bladder, enlargments of the prostate, and the whole subject of diagnosis by the aid of the cystoscope, were, as might be expected, well illustrated—Mr. McGill of Leeds, Mr. Vincent Jackson of Wolverhampton, Mr. Hurry Fenwick of London, Mr. Southam of Manchester,* Mr. Bennett May, and Mr. Oliver Pemberton being amongst the principal contributors.

Mr. Vincent Jackson also showed "a drawing of a tuberculous ulcer on the tip of the tongue, and which was successfully removed from a middle-aged woman." It would be of interest to know what was the proof that the ulcer was tuberculous, and what has been the sequel of the case.

The following specimens shown by Mr. Bennett May, of Birmingham, were from cases of certainly very exceptional interest:—

A Toothplate with Teeth, successfully removed by Œsophagotomy, after fifteen months' impaction.

A piece of Bone lodged in Larynx for thirteen months, and successfully removed by Tracheotomy.

A Halfpenny successfully removed by Œsophagotomy from Mediastinum Thoracis, after four years' impaction.

An Enterolith successfully removed by Enterotomy from a case of intestinal obstruction.

I was in Birmingham only two days, and my duties as president of the Dermatological Section prevented my attending the meetings in any of the others. I can therefore only state that I was told that all the Sections were well filled and the discussions vigorously kept up.

* One of Mr. Southam's specimens was of especial interest for me, since it appeared to prove the influence of local irritation in the causation of cancer. It was described as follows in the catalogue:—"The bladder of a male, aged 40 years, containing a cancerous (epithelionic) tumour, which appears to have originated at the site of a recto-vesical fistula. The fistula, which had been present for about fifteen years, had followed the removal of a large calculus by lateral lithotomy."

In the Section for Dermatology we had arranged for a discussion on a special subject every day (three mornings). This did not leave much time for original papers, but a selected few of these latter were read.

On the first morning Dr. Radcliffe Crocker introduced the subject of Alopecia Areata, and to my great satisfaction avowed himself a convert to the belief in its parasitic origin and its alliance, if not its identity, with ringworm. He wished to distinguish one or more forms of the disease, but for the more common and well-marked cases he was willing to go back to the old name and call them "Tinea Decalvans." As these ARCHIVES are designed for the record of my own opinions and observations, I shall perhaps not be accused of undue egotism if, leaving my readers to consult Dr. Crocker's able paper in the pages of the Journals, I here reproduce only the substance of my own speech in the debate which followed.

I remarked that I had been greatly interested in Dr. Crocker's paper. It entirely confirmed the opinions which I had myself long held and taught on the subject. In a statistical paper based on the experiences of the disease at the Blackfriars Hospital for Skin Diseases, which I had published in the *Medical Times and Gazette* about thirty years ago, I had expressed the view that alopecia areata was distinct from ringworm, that it had no cryptogamic cause, and that it was for the most part not contagious. That paper had often been quoted by subsequent writers. I had, however, not long after it was written, seen reason to mistrust some of its conclusions, and as years had gone on and experience had ripened, I had felt more and more certain that the negative results of microscopic examinations had misled me. It was more than thirty years since that paper was written. During the last twenty years I had always held and taught that the common form of alopecia areata was in all probability a result of cryptogamic disease, and that it was in fact a sort of modified ringworm, or at any rate a sequel of that disease. I did not believe that it had a fungus of its own, but held rather that it depended upon that of ringworm. In a large majority of cases I held that alopecia

occurred in those who had previously suffered from ringworm, and often on precisely the same spots. My attention had first been drawn to this point by a remark made to me by a distinguished London physician, who was himself the subject of alopecia. This gentleman stated that he had in childhood suffered from ringworm, and that one troublesome patch was exactly where that of alopecia now occurred. Since then very numerous cases had come under my notice which confirmed this view. I had treated patients for alopecia whom I had myself previously treated for ringworm. I had also seen alopecia occur in a calf which was known to have had ringworm before. The interval between the two diseases might vary from a few months to many years. In more than one case an alopecia patient, who had at first denied any previous ringworm, had found on inquiry at home that he had really had it in childhood. Under the head of typical or common alopecia areata, I would include all cases in which the feature of areation was well marked. In these cases the patches had abrupt margins, spread at their edges, and were never symmetrically placed. They very frequently began on the occiput, and in these cases it might be suspected that the contagion was effected from the back of a chair. In cases in which alopecia was not a sequel of ringworm in early life, I believed that it occurred from direct contagion either from another alopecia patient or from ringworm. The cases of loss of hair which could be reasonably suspected of being of neurotic origin, were quite distinct from alopecia areata. The baldness was either symmetrical or definitely one-sided, never irregular. I believed that it was impossible for nerve causation to produce round patches, or to cause patches to spread at their edges. Areas of disease which were really neurotic always occurred in the distribution territories of nerves, and were never infective at their edges. Thus herpes and morphœa, our types of neurotic skin diseases, never prove serpiginous. Alopecia, on the contrary, is always so. When, in connection with alopecia, there is a history of dyspepsia or of headaches, &c., probably the connection is merely accidental. I had seen abundance of alopecia cases in those who were in excellent health. I congratulated the

author of the paper on his recognition of alopecia areata as one of the cryptogamic family, and felt sure that it was a decided step in advance.

On our second morning, Dr. Bulkley, of New York, read an interesting paper on Factitious Eruptions. It was replete with well-observed facts, but was perhaps too detailed for the occasion; and the pressure of other business did not permit of our entering on the discussion of its important topic. Dr. Mapother next read a paper on the use of mercury in the treatment of psoriasis. This interested me, because I have long held that mercury is beneficial to some extent in all forms of inflammation, and tends under all conditions to repress and restrain the processes of cell growth. It was even, as I remarked at the time, used and recommended as a remedy for psoriasis by some of the older surgeons (Turner, to wit). However, Dr. Mapother had new facts for us, and although I do not think—with our modern knowledge of what arsenic and chrysophanic acid can do—that we are likely again to fall back on mercury, yet I felt indebted to him for recalling attention to its influence on the disease.

One of the most interesting events of the Section was the demonstration by Dr. Brooke, of Manchester, of a most remarkable example of Lichen Spinulosus (it has many other names) in a child. He had been zealous enough to bring the child from Manchester for our inspection, and had prepared an excellent statement as to what prior observers had done in relation to this very rare malady. No doubt Mr. Brooke will publish a full account of the case when complete, and I will therefore not anticipate further than just to say that one most important and I think novel feature had been made out, namely, its contagiousness. The disease in the patient had been present only a few months, and already several other children in the family were suffering from a similar eruption. It may be conjectured that, although totally different in external appearances, the disease really belongs to the same family as Molluscum contagiosum. Both probably have their contagious element in some hitherto undiscovered psorosperm. It is a very remarkable feature, and one to which I have repeatedly asked attention in reference to molluscum, that its cause, whatever

it is, appears to be unable to perpetuate itself. The eruption always comes to a natural end after a certain duration. We never see cases of persistent molluscum contagiosum.

At our second morning meeting, Mr. Malcolm Morris introduced for discussion the subject of *Vaccination Eruptions*, and prefaced it by the following questions:—

1. Is there such a disease as "vaccine generlisée" due to blood infection; or are all the secondary vesicles, following vaccination, produced by external inoculation?

2. Are the general evanescent eruptions (Roseola, &c.), following vaccination, caused by a specific poison, or are they due to a foreign body in the blood acting mechanically (Behrend)?

3. Is it possible to transmit syphilis during the latent period by means of vaccination?

4. How is the occurrence of such apparently different skin affections as eczema, psoriasis, urticaria, pemphigus, &c., following vaccination, to be explained?

5. Is there any reason, so far as the protective influence of vaccination is concerned, why the vesicles should not be treated antiseptically, after the eighth day, so as to prevent the risk of accidental local inoculations?

In speaking of Mr. Malcolm Morris's able paper, I endeavoured to keep close to his propositions. In the first place I avowed my belief in a true exanthem as a not very infrequent sequel of vaccination. All observers had, I thought, seen it, and the wonder was not that it should occur, but that it did not occur in all cases. It stood in the same position as the eruption after inoculation, and although usually very slight, might in some cases be severe. In some cases it might even be gangrenous. It was to be distinguished from all accidental eruptions, and especially from the so-called impetigo contagiosum, by the facts that it always occurred within a definite period, was always symmetrical, and always disappeared spontaneously after a short duration.

Impetigo contagiosum was, I suggested, an unfortunate name for an eruption which was always attended by vesications and never by pustules. The New Sydenham Society's portrait might be taken as a good type illustration of the malady. The disease was just the same whether it begun from lice on

the head, from vaccination, or from a scratch on the hand. The pus secreted was contagious, in exceptional cases virulently so, and a whole household might suffer. I stated that I did not know of any severe English epidemics of this malady, but there had been many recorded on the Continent. The eruption was easily cured and left no ill consequences. Although it was necessary to give it a place as one of the occasional accidents from vaccination, it was unimportant.

As regards proposition No. II., I had to confess that I did not know what was meant.

In reference to the possibility of conveying syphilis from a vaccinifer who did not reveal the taint by any visible symptoms or any degree of cachexia, I felt bound in honesty to say that I felt sure of it. No surgeon in his senses would ever vaccinate from a child which showed obvious symptoms. The fact is, however, that a certain number of syphilitic infants look perfectly healthy whilst yet very efficiently contagious. There is no use, and much danger, in denying this important clinical fact. It has its parallel in the fact that many subjects of acquired syphilis pass through the secondary stage without a single symptom. I instanced the case of the vaccinifer in my first series of cases.* In this instance the vaccinifer was pronounced by the station-operator to be a good specimen of a healthy child, and was taken by a very able and judicious practitioner to a private house, for the purpose of arm-to-arm vaccination. Fourteen persons acquired syphilis, yet on the most careful examination of the infant afterwards nothing could be found of a suspicious nature, excepting a little sore at the anus. Concerning this latter, some, including Sir John Simon, who saw it, doubted whether it could be considered proof of taint. In my second series of cases the vaccinifer did not present a single visible symptom. Had it done so, it would have been rejected at once by the vaccinator, a well-experienced and very careful man. It is absurd to assert that inherited syphilis is always to be detected, and it is a cruel injustice to imply that all accidents have been the result of carelessness. Very fortunately it would appear to be the fact that but few syphilitic

* See Transactions of the Medico-Chirurgical Society.

infants have the virus in the vaccination lymph. No doubt many have been used as vaccinifers, and very few accidents have occurred. Dr. Cory's experiments support this view, for he, although using lymph from those who were known to be syphilitic, failed on several occasions. At last, by perseverance, he unfortunately succeeded. No good can possibly come from concealing from ourselves or others the real facts as regards the danger of syphilis from vaccination. Our only safety lies in their recognition. Not only must the careful vaccinator examine as to the state of health of the child he proposes to take lymph from, but he should know the parents, and will do wisely to avoid, as a rule, all first-born children. The cheering part of the story is that these accidents are very infrequent. Since the publication of my second series of cases in 18—, no single case of vaccination-syphilis has come under my observation. None have, I believe, been published in our English literature, and the officers of the vaccination department are able to assure us that, during twenty years of close attention to the matter, they have not found any amongst those vaccinated at their offices.* When we remember that during these periods a whole army of anti-vaccinators have been ceaselessly on the look out for facts by the help of which they might discredit vaccination, we may feel sure that in English practice during the last quarter of a century, at least, the communication of syphilis by vaccination has been infinitesimally small in amount. It would be a pleasure to myself if I might believe that the publicity given to the cases which came under my notice twelve years ago had been the means of causing increased care, and of thus helping towards the result of an entire absence of such cases during the last ten.

As regards the adoption of so-called antiseptic precautions in vaccination, I cannot say that I felt much zeal. I go, however, with Mr. Morris thus far that I think many cases of badly inflamed arms, of erysipelas, and contagious impetigo

* I make this statement on the authority of one given by Mr. Ernest Hart. It must not be understood to be more than literally true. It means simply that the vaccination officers have inquired for cases, and that none have been reported to them. It does not mean absolutely that none have occurred.

might be prevented if mothers were instructed to apply vaseline during the stage of scabbing, and to protect the arm with cotton-wool.

At the Hospital for Syphilis and Skin Diseases, Mr. Gilbert Smith had kindly collected for our inspection a group of rare cases. I will briefly record from memory what most interested me.

A boy of about fourteen showed that rare variety of cicatricial Keloid which assumes the pedunculated condition. As a rule, keloid sends out spurs into the adjoining skin, and its edges do not in the least become overlapping. Now and then, however, the growth is so free that the edges do overlap, and a sort of table with a very thick pedestal is produced. I have in several cases seen this condition developed to some extent, but never to anything like the degree present in Mr. Smith's patient. The finger could be put under the overhanging border at all parts, and the growth might be lifted away having a pedicle not more than a fourth of its whole extent. As usual in this form of keloid, the growth, although very firm, was less hard and much less glossy and smooth than in the more common variety which sends out spurs. It was exceedingly tempting for excision.

A young woman of about eighteen presented a good example of the eruption which is illustrated in plate of the New Sydenham Society's Atlas. It is an eruption to which I ventured to give the name of summer prurigo, or pruriginous acne of adolescents. Its peculiarity is that it affects the exposed parts, hands and face, is always worse in summer and nearly well in winter, and that it usually undergoes amelioration, or even disappears, when adult age is complete. The eruption consists of dull red papules which never suppurate, but always leave scars. They are scattered over the face and neck, and sometimes over the shoulders and back. Often, but not always, they are seen on the backs of the hands and forearms. They almost always itch and burn in hot weather. In the subject of the New Sydenham portrait, the disease entirely left the patient at the age of 22, after he had been during at least ten summers under my observation with it. It left him, however, with the skin of his face and shoulders marbled over

with scars. In certain cases in women, however, it persists through life. Mr. Gilbert Smith's case was an excellent example of the malady, and the patient gave the usual facts as to history. She was stout, florid, and in fairly good health, She had suffered for some years. She was, according to my experience, likely to do so some years longer. Some other observers present were inclined, I believe, to name the malady urticaria perstans, but its restriction to certain parts, the absence of true wheals, the conspicuous influence of sun and summer, and the fact that scars are produced, constitute features in which the malady differs from all forms of true urticaria.

A very delicate-looking woman of about 57 presented conditions which all present acknowledged as a somewhat exceptional form of bat's-wing lupus erythematosus of the face in association with a yet more exceptional form of eruption on the trunk. The opinions of the specialists present differed much as to how the latter should be named. It consisted of a faintly marked lichenoid and slightly erythematous eruption which covered the lower part of the back and buttocks in very large patches which in most parts had abrupt borders. Over the shoulders and upper part of the back there were here and there some very superficial scars which had apparently been left by the spreading eruption. Some thought that there must be syphilis in the case. Of this I could see no evidence, and my interest was claimed by the fact that the patches in the trunk were very like those which I have described at page 22 of ARCHIVES, Vol. I., in a case in which a lady became profoundly cachectic with persistingly high temperatures and an eruption which I held to be a variety of erythema-lupus. Mr. Smith's patient looked very feeble, and complained of being always very chilly. This symptom was present also in my case. The form of disease of the skin, so far as the body is concerned, is one which has not I believe been hitherto described. That on the face was a sort of connecting link between common lupus and the erythematous type. It is very unusual for lupus erythematosus to spread over the surface of the body, and when it does so it is always a very serious disease, often I think a fatal one. I have seen a few examples of it, and shall

have to mention presently a remarkable case, a wax model of which I had the pleasure of seeing subsequently in the temporary museum at the Berlin Congress.

Amongst the In-patients was one of very special interest to me, an example of paraplegia in an early stage of syphilis. The patient, a man of near thirty, had been of remarkable vigour. He was now in bed with almost absolute loss of sensation and motion in both lower extremities and incontinence of urine and feces. It was, I was told, only about nine months since his primary syphilis, and he had suffered from some secondary symptoms in throat and skin. Suddenly he began to have pain in his back, and in the course of a few days lost the use of his lower extremities, sensation failing at the same time. The reader may find at pages 148 and 188 of my work on Syphilis the narrative of a very similar case. I have seen but very few such, and have never had an opportunity for making an autopsy. The symptoms would point to a myelitis. The earlier in the course of the disease it occurs, the more severe it is and the less the probability of recovery. Yet in most cases probably recovery to a certain point does occur. In a clinical lecture some years ago published in one of the Journals, I recorded some examples of permanent recovery but with partially disabled extremities. They were, however, all instances of its occurrence at a later period of the malady.

My mission in Berlin (as an individual) chiefly concerned the desire to gain converts to the true faith as regards the cause of Leprosy. With that object I exhibited there (as had been done also at Birmingham) a "Leprosy Globe," which is in itself an eloquent argument. It shows in the most striking manner that the disease chiefly prevails on islands, and along the sea-boards of continents, and that in these situations it may be met with over almost the whole world. I had opportunities afforded for bringing the subject forward for discussion twice: first in the Section for Dermatology, where the pathology of the disease was discussed, and subsequently, at the wish of Dr. Hirsch, in that for Climatology, over which he presided. On the latter occasion I dealt chiefly with geographical distribution, and the history of its decline in some places and increase in others. Many authorities on

the disease were present and took part in the debates, amongst whom may be mentioned Dr. Hirsch himself (the author of a most able and judicious article on it); Dr. Unna, of Hamburg; Dr. Arning, the Sandwich Island investigator; Dr. Peterson, of St. Petersburgh, and Dr. Leloir, the author of the most recent and complete treatise on it. Without being able to say that any one distinctly avowed himself a believer in the fish-hypothesis, I yet believe that definite advance was made. The terms of the hypothesis had not been understood before, and I was told by several that, after hearing my arguments, they regarded it as a far more plausible theory than they had previously done. Above all, I am entitled to note that no one else advanced any hypothesis whatever as to cause, and that although Leloir and others stood up for the theory of spread by contagion, and Dr. Hirsch for that by heredity, others expressed great scepticism on both these points. A paper was read by Dr. Beaven Rake (who was not present) which to some extent supported my views. Dr. Arning had with him some valuable photographs, and exhibited in the museum an important series of casts, &c. From him I got the most valuable new fact which was elicited in the whole discussion, and one the knowledge of which would alone have repaid me for the journey to Berlin. Ever since attention was attracted (some twenty years ago) to the remarkable spreading of leprosy in the Sandwich Islands, I have expressed the belief that some new methods of cookery, or some novel form of fish-food, must have been introduced by the Chinese. All believe that the Chinese spread the disease, but have assumed without exception that it has been by contagion and not by food. Dr. Arning told us that it was undoubtedly true that, although fish had been largely consumed by the natives long before leprosy became prevalent, yet that the use of it in a salted state was new. Although not introduced by the Chinese, its employment had been about simultaneous with their immigration. This was exactly the fact which I wanted, for SALT fish is precisely the article most under suspicion as the cause of the disease.*

* The use of fish in a salted state has become so common now, that the lepers in the settlement at Molokai receive a daily allowance of near a pound a day, chiefly salmon.

In the discussion on Leprosy before the Dermatological Section I defended the following propositions, which, with a view to definiteness, I had had printed and put into the hands of those present.

Leprosy is everywhere the same disease.

The discovery of the Lepra bacillus has made the problem of the cause of Leprosy much more simple.

It is certain that the bacillus must be received into the body either by direct contagion or in the form of food.

It is certain that neither contagion nor hereditary transmission take any important part in the spread of Leprosy.

Englishmen who have acquired Leprosy abroad may return home and live amongst their friends without risk of communicating the disease.

Englishmen who, without any possibility of inheritance, go to reside in leprosy districts, may become Lepers, and without any known exposure to contagion.

It is clear then that the bacillus of Leprosy must in almost all instances be received in the form of food.

The only kind of food open to suspicion in *all* the various regions where Leprosy is endemic is Fish.

The statements adverse to the Fish-hypothesis of Leprosy will probably in the future be found to depend upon errors in observation.

The department of the Berlin Congress Museum which most interested me was a series of models and photographs collected by Dr. Lassar. Some of these were so good that it was almost equivalent to inspecting the patients themselves. Unfortunately little or no attempt was made to give information as to the case-histories, and the diagnoses recorded in the names appended were not in all instances out of the reach of debate. A magnificent model in the centre represented the head and bust of a young man, the subject of the very rare form of Lupus erythematosus which spreads over the whole body. I have already, in speaking of one of Mr. Gilbert Smith's cases at Birmingham, adverted to this malady (see p. 108). Dr. Lassar's model showed the chest, shoulders, neck, and ears occupied by diffuse erythema, which was desquamating in parts. How far it extended down the trunk could not be seen. On the face and scalp were quite characteristic conditions of erythema-lupus in isolated patches. There were some superficial scars. Curiously the one hand which was shown was not severely affected, there being only a single patch on the back of it. On the scalp the

hair had been extensively destroyed, large bald patches remaining in a state of partial cicatrix, and with scattered tufts of hair collected in the brush-like manner. The ears were red and swollen, but not ulcerated. From the nose itself and the adjacent parts of cheeks and forehead, the disease appeared to have receded.

Dr. Lassar showed also many models illustrating the effects of treatment in lupus, acne, rhinophyma, &c., and one in which congenital ichthyosis, of the black papillary type, had been almost cured (presumably by cutting or scraping the growths away). There was also one model showing a form of psoriasis inflammation affecting the scars left by cupping. The patient had apparently been the subject of psoriasis before the cupping. Dr. Payne, who examined these models with me, told me that he had seen common psoriasis occasionally evoked by injuries, and it is probable that its preference for the elbows and knees is to some extent due to the pressure to which those regions are exposed.

By far the most interesting to myself of Dr. Lassar's collection was, however, one which was labelled Lupus erythematosus, and which showed a serpiginous nævoid condition on the forearm and hand of a young child. Plate IX. in the Archives illustrates exactly the same disease, and when I published it six months ago I believed the case to be unique. Dr. Jamieson of Edinburgh was good enough on reading it to send me the narrative of a similar one, which the reader may find at page 71. The peculiarities of the condition are that an exceedingly superficial florid stippling of the skin spreads in a serpiginous manner over the limb during the course of years, producing satellites and leaving very delicate scars. In my case there was the history of a very small congenital nævus as the point of origin, but the young lady when I saw her was fifteen, and the disease was still spreading. It is clearly an infective process, and little outlying discs are produced totally unlike anything which we recognize in ordinary nævus. These discs spread at their edges and become rings. The reader must be good enough to turn to the plate if he would get a good idea of what is meant, and he may accept my assurance that Dr. Lassar's model was in all respects

exactly like my drawing.* In Dr. Lassar's the disease had spread from above the elbow over the whole of one side of the forearm, and to the hand even to the end of the thumb. The conditions were most pronounced near the elbow, and became very faint in the hand, just as will be seen in my portrait. Dr. Lassar named his Lupus erythematosus, and no mention was made of nævus; but as it was clearly the arm of a young child, the suspicion that some slightly marked nævus was present at birth is not improbable. I named mine "nævus-lupus," recognizing in that name its origin in congenital peculiarity and its assumption of infective and serpiginous qualities. I have no doubt that the disease is a near ally of what I have named Lupus lymphaticus, for in the latter, in addition to the lymph vesicles, &c., there are little tufts of dilated vessels just such as are seen here. In these cases, however, there is no lymphatic element, the changes being vascular only.* I had fortunately my drawing with me in Berlin, and had opportunities of showing it by the side of Dr. Lassar's model to Dr. Unna, Professor Kœbner, and Dr.

* The following extract from my note-book gives, perhaps, a more precise description of the conditions in Dr. Lassar's case:—"The back of the forearm and hand showed superficial red stains abruptly margined. The large patch, which was composed of conjoined smaller ones, consisted of ill-marked rings and half-circles. On the hand itself the changes were more superficial than in other parts, and exactly those presented in my own portrait. There were minute tufts of dilated capillaries arranged partly in rings and partly in dots. The condition extended to the very end of the thumb, becoming fainter and fainter as it advanced. It extended above the elbow to a certain height."

* Since the above was in type I have received from Dr. Wittrock (Dr. Lassar's assistant) the following details of this important case. It will be seen that they appear to connect it closely with true Lupus Erythematosus. The early age at which it began is, with the history, very remarkable.

"Charlotte Schmidt, aged three and a half years, was born perfectly healthy. Her parents were also healthy. The child suffered with difficult teething, and got sometimes convulsions during this time, but remained otherwise in good health. At the age of nine months, there appeared, on both cheeks at the same time, a few small red spots; at first a few spots only of the size of a very small pea, later on a larger number until the rash got the size of a florin on each cheek. The colour of these spots was a rather clear red; the skin between the spots also a diffuse red. A few weeks later the affection began on both ears, but did not spread much.—A whole year later the disease began on the arm. There appeared on the right upper arm large and diffuse spots of an intensive red. These spots spread during eight weeks from the humerus unto the dorsal part of the right hand. The mother is sure that a nævus never existed on the body of the child."

Payne, none of whom doubted as to the identity of the disease in the two cases. In Dr. Jamieson's case there was no history of congenital nævus, but the patient was young and the condition had begun in infancy, so that it is quite possible that some congenital vascular peculiarity had been present although not noticed. It is to be remembered, however, that the facts are precisely similar as regards Lupus lymphaticus. Some of the examples of the latter are in association with nævi, and others are not. All, however, begin in early life, and thus, as already said, suggest suspicion of congenital peculiarity of tissue.

I am not unaware that some writers, adopting what appear to my mind narrow and conventional definitions of the words, have objected to the name Lupus lymphaticus. It was therefore with interest that I observed that Dr. Lassar had quite independently used the term lupus for what I had called nævus-lupus. There is no doubt that in the one case the morbid process is that of a lymphangioma, and in the other of an angioma, but these names are those of pathological anatomy only, and do not comprise any reference to the clinical features of the malady. It is in the latter that the lupoid characters appear. It is a new conception of lymphangioma to be told that it may prove infective, spread by satellites, &c., for twenty years together, disorganize the affected skin and leave scars. These are the qualities of a lupoid affection. I have never taught that "Lupus lymphaticus" is the same thing as either lupus vulgaris or lupus erythematosus. It is undoubtedly very different from both, as they are very different from each other. They all, however, belong to one family.

Two models represented the newly observed disease to which the name Pityriasis rosea has been given. They afforded proof that the same name is applied to the same thing in Berlin as in London. Dr. Payne agreed with me that they were very fair representations of this curious malady. They showed patches on the chest which were congested and desquamating, and of which a very noteworthy feature was that none of them approached any well defined form of either oval or round. All were irregular in shape,

like islands with capes or promontories, or still more like so many amœbæ sending out their processes. All the patches were slightly desquamating, and there were a few blood-stained spots as if from scratching. Those who are acquainted with this curious malady will be aware that it presents features of resemblance to ringworm, to dry eczema, and to certain forms of secondary syphilitic eruptions. It is, however, quite distinct from all these, and presents the remarkable clinical feature that, after lasting a few weeks or a month or two, it usually disappears under any treatment or under none at all. Its chief importance is in reference to diagnosis, —that it may not be mistaken for something of a much more serious nature.

Under the name of Acne Necrotica, Dr. Lassar presented us with the face of a young adult man, which showed a symmetrical eruption covering the forehead, and occurring also on the nose and chin. From the nose it extended down the alæ, round the corner of the mouth, and thus as if by contagion advanced to the corner of the chin. The acne spots were small, and were for the most part discrete, and almost all of them presented minute sloughs in their centres. The intervening skin was scarcely at all inflamed. It seemed to be the same disease as that to which the name acne varioloforme has been given, and in the absence of clinical history, a suspicion as to syphilis naturally occurred.

There was also a good model of xeroderma pigmentosum or Kaposi's disease. It showed the face of a girl covered with pigment spots and stigmata. It is to be noted that some of the latter were on the prolabium. The skin was evidently tight and in a condition of sclerodermia. The eyelids were covered with stigmata, and the eyelashes partly destroyed and in tufts. There was some ulceration on the alæ nasi and at the outer corners of the eyelids. The tightness of skin was a prominent feature.

A paper on Intussusception which I read in the Surgical Section was chiefly intended to elicit discussion and expressions of opinion and experience from others. In this, owing to the pressure of business, and with the exception of an interesting speech from Mr. Howard Marsh and some remarks

from Professor Czerny, of Heidelberg, it failed. My recommendations were a vigorous trial of intra-abdominal taxis in the first instance, and prompt resort to laparotomy if needed. I felt obliged to speak discouragingly of the operation in infants under one year, in whom the disease runs a very rapid course, and unless immediately relieved by taxis is almost invariably fatal. Mr. Marsh spoke more cheerfully as regards this group, recommending operation in very early periods, and pointing out that death was inevitable without it. He admitted that but very few were saved, but believed this result chiefly due to delay. Several of those present mentioned to me afterwards cases of most encouraging results from operation.

In the Section for Ophthalmology I had two short papers. The first was on a form of Choroiditis sometimes seen in cases of Osteitis Deformans. Sir James Paget and others have noticed that some subjects of this peculiar disease fail in sight, but I believe that my case is the first observation as to the precise changes which occur. The drawings which I exhibited were from an elderly gentleman, the subject of the disease in a most marked form, who had for years been partially blind. The regions of his yellow spots, and for a wide area around them, were symmetrically disorganized by choroiditis. He was also deaf. The choroiditis appeared to be arrested.

My second paper concerned a form of Choroiditis which has recently much interested me, in which, without any history of syphilis or any derangement of general health, a serpiginous and usually symmetrical disease is set up. It begins close to the temporal border of the disc, and spreads to the yellow spot. The margins of the patch are very abrupt, and sometimes show swelling or a condition of hæmorrhagic thrombosis. In its serpiginous qualities the choroiditis resembles a lupus of the skin, but it is usually quite symmetrical and may occur in healthy persons. The disease has, I believe, not hitherto been recognized.

Part of the morning of Sunday, Sept. 9th, was spent in the museum of the Pathological Institute. This museum is, I believe, almost wholly the collection of Virchow, and he still takes the keenest interest in adding to it. It is not one which a stranger can consult, for the specimens are not displayed or

catalogued. In this respect it differs notably from the collection formed by Rokitanski at Vienna, and from that of our own College of Surgeons. It is, however, full of most valuable material, and the professor is very obliging in facilitating the objects of those who wish to make private research. Fifteen years ago I was allowed to seek amongst its treasures for (amongst other things) the evidences which pathological anatomy can afford as to the characters and frequency of gout and rheumatism in Germany. On the present occasion my eldest son, who was with me in Berlin, had made application to be permitted to examine the specimens of syphilitic diseases of joints, of which the museum contains an exceptionally valuable series. The professor responded to his request by meeting him there and showing him the specimens. I made a third, and we were shown also many other objects of great interest. In the Congress Museum I had seen specimens of intestinal concretions, "Darmsteinen," which were simply so labelled and had no history. I wished to know whether biliary calculi ever formed the nuclei of these. Virchow said that he had no evidence in proof that biliary calculi ever grew bigger in the intestines. He had no specimen which showed any accretion of matters derived from the contents of the bowel. He showed me some very large biliary calculi which had been safely passed per anum. I had previously seen others with the same history in the Congress Museum. I had no opportunity for exact measurements, but I do not think that any exceeded the dimensions of those which were figured in the last number of the ARCHIVES.

Returning to the subject of "Darmsteinen," the professor showed us a large concretion removed from the bowel after death, in the middle of which was a plum-stone. The puzzle presented by such specimens is to tell why the nucleus itself did not readily pass, seeing that bodies far larger so frequently come away without inconvenience.* Probably these instances

* A country practitioner whom I knew when young, used when consulted by anxious mothers whose children had swallowed halfpence, &c., to content himself with the time-honoured joke, "Was it good money, ma'am?" "Oh, yes!" "Then you may be sure it will pass." Yet that this is not

of retention and accretion are from cases in which pouches or strictures or other mechanical causes of impediment existed. We were shown, however, two other specimens bearing upon this topic which were of very special interest. They were much alike, and in each instance consisted of a concretion of a reddish colour, and about as big as the last joint of a large thumb. In each instance the concretion was removed from the duodenum of a man. Virchow told us that the first had caused much speculation and bewilderment as to its nature and mode of origin. When, however, the second case occurred, it was then noticed that both the patients were artificers in the same occupation, that of painters. On inquiry the fact came out that they had been in the habit of drinking varnish, a solution of shell-lac in spirits of wine. The concretion in each represented the shell-lac with additions. Why should concretions so arising remain in the duodenum, and not pass lower down and escape?

German museums of pathology contain many specimens of a class which ours in England are not rich in. I refer to those illustrating diseases artificially produced. Virchow was particularly interested in demonstrating to me that the administration of phosphorus to animals might produce diseases of the bones which were not distinguishable from the results of syphilis. He showed a large series of specimens exhibiting caries and necrosis of various bones. He insisted on the point that a chemical poison produced similar conditions to those which in the case of syphilis are attributed to a vitalized one. I was interested not only in this fact, but also in the fulness of the proof afforded that the internal administration of phosphorus could cause bone disease, since it has perhaps been too much the habit to assume that the necrosis of the jaws is the result of direct action of the vapours on carious teeth or exposed alveolus. I published some years

quite universally the case is proved by certain exceptional specimens in our museums.

The *Canadian Practitioner* for the present month contains the record of a case in which a boy of 7 retained a cent, which he had swallowed, for ten months, and finally voided it. The coin measured an inch and an eighth across. It had not given much trouble.

ago* the case of a lady who had extensive necrosis of the lower jaw from very prolonged administration of phosphorus pills, and it was, I believe, received with a certain amount of incredulity.

We were also shown bones from two infants, twins, in which those of one showed extensive evidences of inherited syphilis, and those of the other none whatever. I have often insisted upon the importance of investigating the facts as to twins in reference to inherited syphilis, and also other heritable taints. It is by no means improbable that one fœtus may wholly escape and its brother suffer, and this fact if proved would be very important in helping our belief as to what takes place in transmission. I have myself published cases in which one twin appeared to escape, and the specimens in Virchow's collection afford further and very valuable proof that such apparent escape may be supported by the evidence of the autopsy. Unfortunately for those who, with myself, are believers in the possible latency of the taint, although still in reality present, they by no means prove the whole theorem (that of two conceptions occurring together, one may be attended by communication of the taint and the other not).

The usefulness of these meetings is by no means confined to the addresses or sectional meetings or museum-exhibitions. The Scotch servant-girl when enjoined by her mistress to come straight home from church, positively declined to promise, remarking that she "would not give the crack i' the kirk-yard for a' the sermon." So often with us the set discourse in the Section-room is less pleasant, and even it may be less instructive, than the chance conversation before or after the meeting. Neither at Birmingham nor Berlin did we shun "the crack i' the kirkyard." At Birmingham half the dermatologists of Great Britain and Ireland were present, and the Continent and the United States were well represented. Opinions were interchanged freely, and private debates took place which would not be recorded in the Journals. At Berlin nearly every one was there, and you might seek a confidential opinion upon any favourite topic from the chief authority on it, whether in Europe, or America, or the Colonies.

* See Transactions of the Clinical Society.

In Birmingham I had been assured by a local authority that syphilis there was a very mild disease. The severe cases, which were very rare were, he thought, always contracted somewhere else. At Berlin, an authority from Australia of great pathological experience mentioned to me quite spontaneously the same fact. "We never see in Melbourne," he said, "the severe forms which are described in English books. Nothing is less common than for us to find disclosures of syphilis in the *post-mortem* room. Of brain syphilis we have no specimens." These statements would, I believe, be echoed by observers in many other places. Every one thinks that syphilis is more rife and more severe in other places than where he chances to practise. The explanation is I think to be found not in one direction, but rather in two. In the first place our recent literature has given, by the record of rare cases as if they were common, a much exaggerated picture of the disease as a whole; and in the second, the last twenty years have really witnessed, by the introduction of better methods of treatment, a very definite amelioration of the malady in all its several stages. I do not for a moment believe that Birmingham syphilis is a milder disease than the London type.

At Berlin, as I have said, almost all the European authorities on Leprosy were present. Many were the opportunities for discussion which were afforded. In the Gardens at Potsdam three of us agreed that the topic should there be tabooed, but a fourth joining the group and in hot zeal propounding a much-debated question, our good resolutions vanished, and during the next twenty minutes we had travelled over much ground. At the Potsdam Station, on our return journey, I was accosted by my quondam London friend and associate, Dr. Bäumler, now and for long the distinguished Professor of Medicine at Breslau. He wished to speak to me on a subject in which I should, he felt sure, take interest—the occurrence of prolonged febrile disease in association with a persisting eruption like that of erythema nodosum. I found that he knew only of a paper of mine which was written many years ago, and was not referring to the two most unusual cases which I have recently recorded in the ARCHIVES. These he had not read. I found

on further conversation that Dr. Bäumler had come across cases not unlike these latter, and that he had collected and was about to publish some others which had been noted by other observers. When I published mine, I admitted my ignorance of any literature on the subject, and solicited, but without success, any information on this point from my readers. Dr. Bäumler has been more fortunate, or more industrious, and if the cases which he is about to record should prove to be, as I believe, of the same kind as my own, we shall, I think, be enabled to add a new and valuable chapter to our treatises on Medicine. The cases referred to are usually in the first instance taken for typhoid fever, but they become protracted, and are attended by the development of nodosities in the skin and cellular tissue much like those of erythema nodusum. "Typhoid fever" was the diagnosis confidently given by an eminent physician in one of my cases, and Dr. Bäumler told me that exactly the same had happened in one of his. I shall await with impatience the publication of his paper, for as yet I know only what he told me on the steps of the Berliner-Potsdam Bahnhof.

Amongst other bits of surgical gossip I was told by a fellow-visitor to Potsdam that the paralysis of the left arm from which the German Emperor suffers is of the same nature as that in the child whose case is published at page 64 of the Archives. I cannot vouch for the truth of this, but the history makes it not improbable. If the fact be so, they are both examples of an exceedingly rare accident.

After the Congress was over, my son and I returned *viâ* Hamburg, in order to see the New Hospital there and to visit Dr. Unna and his private institution. We had a day in Hamburg, and were much pleased and interested by what we were shown in the two institutions named. The New Hospital at Hamburg was only finished within the last two years, and is perhaps the best example of elaborate arrangements for the restoration of health which yet exists. It has apparently been designed almost regardless of expense, and reflects great credit on the city which has built it. It is a mile out of Hamburg, and may be described not as a village hospital, since such a term might mislead, but rather as a

hospital village. Dare I say that there are nearly a hundred detached erections? I forget whether I am a little over or a little under the mark. Attached to the village is what might, by its tall chimney, &c., be mistaken for a factory for the supply of accidents, but which is really the laundry, &c., of the establishment. The great number of separate buildings has been necessitated by the desire to prevent contagion and by the wish to avoid many storeys. Most of the pavilions are of one storey only. There is a detached ward, or rather series of wards, for diphtheria and another for palmar abcesses, and of course one for syphilis, and perhaps less of course one for delirium tremens. Curiously when we were there the syphilis block had no patients, but I am sorry to record that the delirium tremens ward was full. The absence of syphilis is to some extent to be explained by the existence of another hospital for it in the city.

The arrangements for securing asepticism are in all departments admirably complete. The whole institution is under the able and zealous surgical care of Herr Schede, who on the morning of our visit conducted a large party from the Congress over it. It is a misfortune that there is no medical school attached. There is not a place in the world to which the expression "walking the hospital" would be more appropriate, nor than Herr Schede many teachers under whom students would be more likely to profit.

We witnessed an excision of one half of a large bronchocele by Herr Schede, which was done very carefully and very skilfully. He told me that he had done a considerable number of these cases, and, so I understood, some complete extirpations, and that he had not as yet in any case witnessed any tendency to cachexia strumiprava or myxœdema. We were shown in the wards a gentleman who was doing very well on the eighth day after an excision of the pylorus. We saw also an instance of excellent motion at the hip joint, with ability to walk on the limb and no slipping up and down at the joint, after a modified resection of the hip. In the same patient and on the same day the wrist of one hand had been excised, with excellent results. Such operations may be taken as proof that the surgeon performing them has the fullest con-

fidence in his antiseptic precautions. Herr Schede told me that stone is not common in Hamburg, and gout he thought very rare. Diphtheria is common, and tracheotomy for it a frequent operation and very fairly successful. Most of the patients in this hospital pay something. Even the well-to-do are allowed its advantages if willing to pay according to their means. The subject of the pylorus case just mentioned was, as said, a gentleman of means, and had a separate and very comfortable room.

Dr. Unna's establishment is a private one and wholly under his own management. It is for the treatment of intractable skin diseases. His patients, as is not uncommon on the Continent, do not appear to make any difficulties as to being seen by visitors, and as a matter of fact Dr. Unna does a good deal of teaching. He has a number of lepers under treatment at present, and believes that he is doing them great good. These and a number of other very interesting cases were shown to us. Here again we had the pleasure of meeting a very considerable section of the London Dermatological Society, like ourselves on their way home. We passed two hours very instructively and pleasantly.

SARCOMATOUS ERUPTION SIMULATING SYPHILIS.

Multiple Sarcomata of the Skin developed with such rapidity and abundance that the case was at first supposed to be a syphilitic eruption—Death in about two months from the outset.

The subject of the case was a young married man of dark complexion. He had always previously enjoyed fairly good health, but I was told that he habitually looked pale and was not very robust. The eruption for which I was asked to see him had made its appearance for the first time only five weeks before. He was at the time staying at Dartmouth with his wife for his usual holiday, and was not feeling in any way ill. He was bathing every day in the sea, and on one occasion after his bath noticed some spots on the skin over the region of the liver. As he did not feel ill he did not think much of them, and continued his usual mode of life. A fortnight later he returned to town and showed the patches to his medical adviser. Dr. —— describes them as having been flattish smooth wheals or papules, which he diagnosed as "lichen planus." At this date there was a threatening of other spots on the abdomen and back, and, during the next fortnight, these regions, as well as the face and scalp, became covered. A little later the upper and lower extremities were also spotted over with eruption, but of a somewhat different character from that on the trunk. In the meantime the lymphatic glands in various regions—namely, neck, axillæ, groins, &c.—had taken on enlargement, and had become very hard. At the time that Mr. ——'s eruption began to appear he was not taking any drugs, nor using any article of diet which could be suspected as likely to cause it, and he had never in previous life had any kind of eruption. Nor did he take any iodide or bromide during the early stages of the

development of the eruption. He had been seen by two eminent dermatologists before I was consulted, and by one of these, under a confident diagnosis of syphilis, mercury had been given. He had taken mercury and a little iodide for about ten days before I saw him, and his gums had been slightly touched. I believe that the diagnosis of syphilis had been based in part on the general enlargment of the lymphatic glands, as well as on certain suspicious features in the eruption itself. It is right to state that Mr. —— most absolutely denied having ever suffered from any form of primary venereal disease, or having been exposed to the risk of it.

The following description applies to his state at the date of my visit during the seventh week of his eruption. He was at this time confined to bed, and having had very bad nights in consequence of the pain in his back, which recurred every night. He was feeling somewhat weak, but was not much emaciated, nor did he look seriously ill.

Description of the eruption, October 25, 1888:—

The eruption consists of tuberous nodules developed apparently in the deeper layers of the skin. They are closely adherent to the skin and involve its entire substance, but they do not show anywhere the slightest tendency to ulcerate or to form pustules. They vary in size from shots to small halves of marbles. Many of them are oval rather than round, and in many places, owing to confluence, long irregular streaks have been formed. Over the larger of them the hairs of the part may be seen to grow without any interference or inflammation. In very few instances is the skin movable over a tumour. The parts most severely affected are the middle lines of the chest, abdomen, and back, and on these the spots are placed so closely that the whole skin is covered. Towards the sides of the abdomen and chest, the eruption is less abundant. The face is slightly involved and the patches are here less marked, consisting only of ill-defined lines of induration or wheals, not unlike those seen in true leprosy. Indeed his face has a decided approach to the "leonine aspect" of the latter disease. His scalp is covered over with ill-defined ridges and papules

which are very perceptible to the touch, but less so to the eye. In the conjunctiva of one eye, close to the sclerotic

region, there is a little dusky patch like what is often seen in leprosy. The eruption on the arms is not very plentiful, and

does not differ materially in character from that which has been described on the trunk. On the lower extremities, however, some very noteworthy differences are to be observed. On these parts the spots, which are mostly not larger than split-peas, are very few of them raised, and they are all of them so deeply congested as to be almost black. The appearance at first sight is almost like that of hæmorrhagic purpura; but on careful inspection there is clearly no extravasation. The venules composing the patches cannot be emptied by pressure, and a slight amount of thickening around them is clearly perceptible to the touch. On the upper extremities the spots are fewer on the forearms than on the arms, and there are none on the hands; and on the lower extremities they are fewer on the legs than the thighs, and there are none on the feet. No deviations from bilateral symmetry are to be observed in the arrangement of the eruption. The patches were everywhere, especially on the chest and abdomen, more or less tender on pressure. The colour of those on the legs has been described. Those on other parts are of a dull olive or greenish purple tint. Their colour is everywhere in part due to congestion, and can be modified, but by no means wholly removed, by pressure.

Glandular enlargement.—The enlargement of the glands was very definite; in the neck all the concatinate glands were involved, and to such a degree as to bulge on each side in masses which were quite visible. The individual glands could be easily isolated, and they were very hard. Similar gland masses were present in both armpits and both groins, and everywhere the glands were of great hardness, more nearly approaching the conditions of malignant affections than any other state. No soreness of the throat had been noticed, but on examining it I found on the right tonsil a kidney-shaped ulcer exactly like those with which we are familiar in syphilis, and a similar condition appeared to be beginning on the other side; he was in a condition of slight ptyalism, and it is possible that these conditions were due to mercury.

In attempting a diagnosis of this very unusual case, I first

put aside the suspicion of its being a drug rash, for the reasons that no drug had been given, that the eruption had not developed symmetrically in the first instance, that it had been steadily aggressive, and that the lymphatic glands were involved. On almost parallel grounds, I entirely rejected all suspicion of syphilis. In particular I have never seen in syphilis the slightest approach to such gland disease as was present in this case. That the eruption did not resemble psoriasis, lichen, or any named form of eruption, is sufficiently obvious. It was far too acute for leprosy, and above all we have the rapid and remarkable enlargement of the lymphatic glands as a feature which placed it at a distance from every known form of skin disease. The history of its commencement by a local group of spots on one side of the trunk seemed to imply that whether it was malignant new growth or some form of inflammatory action, it was at any rate infective: by which term I mean that the original spots produced material which, multiplying in the blood, in time became the germs of other patches. With this theory the implication of the lymphatic glands of course fitted well. We had then to choose between the hypothesis of some new type of inflammatory action and that of a malignant new growth. The balance of evidence seemed to me decidedly in favour of the latter suggestion, notwithstanding the remarkably rapid development of the eruption (only seven weeks), its extent, and its peculiarities. My suspicion in this direction received some support from the information given me by the patient's father that his wife had died of cancer (in the abdomen). Her death did not occur till twenty years after the birth of our patient, her son.

I was allowed to excise one nodule for microscopic examination. The portion removed consisted of an ovoid lump about the size of a hazel-nut, and included some of the subcutaneous fat. The latter was of a deep yellow colour and looked jaundiced. On section of the lump it was seen to consist of an infiltration into the true skin of at least a quarter of an inch in thickness, which presented a glistening and moist surface, from which juice could easily be scraped. It was inseparably united to the epidermal layers above, and pre-

sented no definite line of limitation below. Scrapings of its juice showed cell elements in great abundance, mostly small, round, dimly granular cells, with nuclei not very conspicuous. Microscopic sections were declared by experts to be characteristic of round-celled sarcoma.

On October 30, 1888, Dr. B——, Mr. M. B——, and myself met in consultation. Only a week had elapsed since my first visit, but the advance of the disease had been most rapid. The whole of the scalp was now infiltrated and hard, and no separate tumours were to be found. All down the middle of the chest and middle of the back, in like manner tubers had coalesced, and the larger ones having somewhat flattened, a dense thick plate or cuirass was in process of formation. Where the tubercles remained discrete they had increased in size and thickness. Those on his legs especially had become thicker. Most of these at the time of my first visit had been flat, so that they were supposed to resemble purpura, and it needed careful examination to appreciate any thickening; but they now consisted of little tubercles, more or less conical, with pale centres and a dark purple area at their base. The pale centre was evidently due to growth upwards in the middle of the patch, which had compressed and displaced the vessels. The little growth on the sclerotic of the left eye was three times as large as it had been a week ago. It was quite without any inflammatory congestion, and looked as if a portion of liver, half the size of a pea, had been placed under the conjunctiva. There were slight indications of the beginning of two or three similar growths on the other eye.

The most serious feature denoting aggression of the disease was, however, a rapid failure in strength. Mr. C—— looked pale and exhausted and felt faint on exertion, and his pulse was very weak. On the former occasion he had been able to get out of bed and walk about the room easily.

The severe pain which he had had every night in his back was probably one of the chief causes of his exhaustion. There was, however, a degree of breathlessness which made some of us suspect that some intra-thoracic growth was in process of formation. The most probable explanation of the

pain in the back seemed to be the existence of a growth in connexion with the bones, and during the last few days there had been a numbness of the thumb, index and middle finger of the left hand, which probably implied a growth in connexion with the nerves. The patient's state at this visit was such as to make us think that he would not live more than a week or two. Yet the disease from its onset had been present only six weeks.

In our search for the primary growth in this case careful inquiry was made as to any symptoms suspicious of any intestinal or thoracic lesion. None, however, could be detected. Nor on the most careful search could any congenital nævus or mole be discovered on the skin. On the testimony of several of Mr. C——'s friends, he had been looking decidedly ill before he went to the seaside; but he would not himself admit that he had felt so.

In reference to the precise nature of the patches on his legs which had been called purpura, I do not feel any doubt that they were all of them the consequences of local infection. It would appear that on these depending parts, a very early result of infection was thrombosis of the venous capillaries, or their extreme turgescence with blood that was almost black. On careful examination with magnifying power I am sure that there was no real extravasation, and also that there did exist evidences of plugged blood-vessels. It is to be understood that these patches were most of them round, that they began as mere dots and then enlarged to the size of threepenny-bits, the enlargement in extent being accompanied by an increase of thickness in the middle which has been already described.

Those on the trunk differed from those on the legs, I believe, only in colour. The colour varied greatly on different parts. Thus the patches on the face were pale, or of a bluish or greenish tint. Those on the eye were exactly like liver. Those on the trunk were of a dull pinkish or brown tint, and those on the legs were as dark as a ripe blackberry.

On the theory, which is probably a correct one, that the skin lesions were secondary to some large growth existing within the trunk, it is still difficult to explain the remarkably

sudden outburst of the affection, as well as the absolute latency of the parent tumour.

Our patient died somewhat unexpectedly about two weeks after the last note. His death was preceded by several days of intense pain, chiefly in the back. No post-mortem was obtained.

ON CERTAIN DISEASES OF THE LIPS.

It is a matter of common observation that the state of the prolabium is often a good test of health. In many conditions of defective tone, the epithelium of this part becomes dry and may crack and peel. One of the most marked examples of this condition which I have ever seen, occurred in a lady named B——, aged about 30, who was sent to me on account of it, by Dr. Aveling. She had long been under Dr. Aveling's care, and had suffered much from ovarian disturbance. She was greatly out of tone, and was fatigued by the slightest exertion. Her lower lip was not merely cracked and dry, but was liable to have large crusts form on it. These crusts sometimes covered one half of the surface, and were thick and conspicuous. After remaining on a week or two they would loosen at their edges and become detached, leaving an excoriated surface underneath. In the first instance, Miss B—— consulted me in 1881 specially about her lip, and I prescribed for her an ointment and gave arsenic. She came to me again in 1884, and on this occasion on account of acne on the cheeks. It was of the pustulo-erythematous form, most of the pustules being abortive, and there being no comedones. No doubt the acne was due to the same cause as the state of the lips. She was pale, wan, and feeble. Her lip had never got well, but she told me that while she had continued the arsenic, it, as well as her general health, was much better. She had not taken it recently, and the lip was now as bad as ever.

Another excellent example of the same most troublesome condition occurred in the person of a Miss P——, the daughter of a country solicitor. She was 19 years of age, a brunette, tall

and thin. She was exactly like her mother, and in the latter I noticed that the lower prolabium was liable to peel, although it was not definitely diseased. In Miss P—— the disease had commenced about six months before I saw her, and it now occupied the whole of the lower lip, and was threatening the upper one. The lower lip was slightly swollen and everted, and covered with a dryish crust, which peeled off in thick flakes, leaving the surface cracked and sore. The crusts usually cleared off about once in eight or nine days, and during the intervals they could not be got away without causing cracks and soreness. As soon as they had fallen fresh formation began to take place, and the height of the disfigurement was again reached at the end of a week. Miss G—— had had a good deal of treatment before I saw her, had taken arsenic, and used a variety of applications. When she came to me she had just returned from a journey on the Continent, which had improved her health, but left her lip as bad or worse than before. It could not be said that she was out of health, but she was not very robust. She had never had any other form of skin disease. I advised a long residence at the sea-side, and prescribed arsenic and a tar wash. She had been liable for some time before the lip-affection to little round ulcers on the mucous membrane on the inside of the lip. Of these I saw one during the treatment. It was probably herpetic, but it lasted more than a week. It might possibly have been caused by the arsenic.

The case of Mrs. P—— is of some interest as another example of this disease. She was a delicate lady of thin skin. She was the mother of several children, and no special illness had preceded her troublesome local malady. She was, however, decidedly in feeble health. When the lips first inflamed she was living with her husband in India, at Bangalore.

She had suffered from peeling of the prolabium for about a year when I saw her. It was not a severe case, as there was little or no moist exudation; but as her lips were constantly covered with thick opaque flakes, it caused her great annoyance. The flakes would crack transversely, and were detached

about once a week or ten days, when the process of re-formation would again commence.

The influence of climate had not been very marked, and it will be seen that the affection commenced when she was living in a warm air.

Mrs. P——, of New York, consulted me on the kind suggestion of Dr. Besnier of Paris. She was a thin, delicate lady of about 50, who for the last three or four years had suffered very severely from dyspepsia. The diagnosis of a dilated stomach had been given, and she had been subjected to great restrictions in diet. During the last two years she had lost flesh very considerably. It was not, however, for her general health that she came to me, but on account of chronic inflammation of the prolabium of the lower lip. The lip was in exactly the same condition as that described in the three previous cases; that is, it was slightly swollen, and the whole of its red part was covered by a thin opaque crust. I was told that this crust peeled off at its edges, once every week or ten days, leaving the lip looking at first almost well, but with the certainty that in a day or two it would crust over again. The crust did not extend quite to the angles of the mouth. It did not when I saw Mrs. P—— affect the upper lip, but she told me that it had formerly done so to a slight extent. Mrs. P—— had already had the advice of many specialists and physicians, in New York, Paris, and London, but she was rather losing ground in health, whilst her lip remained much as it had been. It was a great trouble to her, both on account of the disfigurement and its soreness. She had no skin disease elsewhere, nor had she ever had sore lips until about a year ago. She told me that she was always better when at sea. I advised that she should try a long voyage, that she should endeavour to take a more liberal diet with some wine, and that the lip should be painted once in a fortnight with a strong ethereal solution of nitrate of silver.

I once saw a very severe case of this disease in a strumous and cachectic lad of about 20. The prolabium of both upper and lower lip was ulcerated and covered with crusts. But the disease was strictly limited to that part. It had been present,

I believe, for some years, and had probably been much neglected. He came under my observation on account of an ulcer on the cornea. He had no other skin disease. He was not my patient, and I never saw him again. The case is an illustration of the intractability of this disease, and its association with feeble state of health.

With this case I will conclude my series of illustrations of chronic inflammation of the prolabium. The four which I have given are clearly all of the same type. They exemplify a disease which becomes conspicuous only by exaggeration. In a great many persons the prolabium is apt to dry and peel more or less. It is by no means accorded to every one to enjoy the condition of constantly soft and healthy lips. It is only, however, in a few that the tendency to peel amounts to a really troublesome malady. The cases given may be held to well illustrate the conditions usually assumed when it does so. The crusts separate once every ten days or a fortnight, leaving the surface red and raw. The process of re-formation soon commences again, and in another ten days exfoliation again commences. Whether the process is more nearly allied to one of seborrhœa or of eczema, or whether it should be affiliated to neither, is a matter as yet in doubt. That it is not usually met with in association with any disease of the skin in other parts I feel tolerably certain. I have seen many other cases than those above reported, and never saw peeling lips in association either with psoriaris or with general eczema.

Unfortunately the subjects of this troublesome malady are usually young women, to whom it is especially annoying. That it is connected in some way with defective tone, there can I think be little doubt. Those who suffer from it only in slight degrees and it may be only occasionally, will often recognize in the state of their lips a good index of general health. It comes also to some extent in connection with exposure to cold and wind. But making all allowance for these two classes of influence, the disease, when once it has got possession, appears to be able to maintain it in a certain sense in its own right. It is not cured by warm weather, nor after the patient has been restored to what appears to be an excellent state of

health. This was very notably the case in the second of my cases just narrated, in that the young lady appeared to be quite well, and through various changes of season and of climate the condition still persisted. As regards treatment, I should incline to regard residence at a mild seaside place for a very long period as by far the most efficient. Tonics and arsenic should be given internally. Externally I have tried a great variety of applications. An emollient lip-salve should of course be most perseveringly employed, not merely once, but many times in the day. In the more obstinate cases I think that benefit has been obtained by painting the denuded prolabium once in ten days with a strong ætherial solution of nitrate of silver.

A remarkable case of Bleeding Fissures in the Lips—Hysteria and suspected malingering—(Abandonment of this hypothesis).

The case with which I shall conclude this paper is one not exactly of the same class as the above. The affection was of ten times the severity attained by them. It presented also distinctive features in the tendency to deep fissures and to attacks of hæmorrhage.

The following are some imperfect notes which I wrote out some years ago.

The most extraordinary condition of the lip which I ever saw was in a girl who was brought to me by Dr. Barnes, and in whom a series of deep gashes divided the prolabium into four or five portions. These easily bled, and sometimes profusely. I saw the patient hurriedly, and only once. If my memory serves me, it affected both the upper and lower lips, but the latter chiefly. She was a girl of 14 or 15 years of age, and the deformity produced was so extraordinary that I suspected at the time that it must have been produced by artificial means. On thinking the case over since, however, there appears no good ground for this hypothesis. It was remarkable that the lip was not materially inflamed, but simply cut in deep gashes.

I saw this young lady only once, but some years afterwards Dr. Barnes was kind enough to draw my attention to the fact that further particulars of it had been published by Dr. White,

of Retford, in *The Medical Press*. I copy an abstract of Dr. White's statements:—"The patient was a little girl aged 14, the child of people in a good position of life. When first seen there were five deep fissures in the lip, from which the blood was flowing freely. The history was that they began as abrasions. It was impossible to stop bleeding except by direct pressure. At first constant, it afterwards became periodic, appearing every two or four weeks, and with other symptoms pointing to connexion with attempted menstrual periods which were not regularly established, and was very scanty when it did appear. Dr. White very carefully examined the blood from the lip, and said that it differed from ordinary blood both in smell and in microscopical character, and that it strongly resembled menstrual discharge. A number of consultations had been held with leading London physicians and surgeons, as the bleeding persisted for months and the patient's life was threatened. There were as many opinions as men, no two opinions being alike. Every possible measure was adopted to improve the patient's general health and to establish the menstrual periods. Some regarded the case as 'lip-hæmorrhoid,' others as 'severe ulceration of the lip;' yet others who regarded the case as one of self-inflicted wounds, and the mischief perpetuated by self-inflicted irritation to the bleeding points. Syphilis was suspected, but denied, apparently frankly so. The girl's father was a thoroughly sensible man with no nonsense about him. On the hint of self-infliction of the wounds being given, he set himself to watch his daughter closely, but thought there was not the slightest evidence to support the supposition. Finally Dr. White had the patient to his own house, chloroformed her and cauterized the fissures deeply with nitric acid, with the satisfactory result that in a week's time they were healed and the bleeding arrested. After the operation the girl had a very high temperature, and hysterical tetanus. The present condition of the lip shows only slight scars where the fissures had been. Dr. White notices that at the time for menstrual periods to appear the lip becomes deeply congested, as if the bleeding would burst forth again. Since the lip has been healed the menstrual periods have appeared regularly. There

is no denying the hysterical tendencies, as since the lip has healed there has been an attack of hysterical paraplegia, and immediately after the operation there was the attack of hysterical tetanus; but in spite of all this, Dr. White does not believe in self-infliction of the wounds, and he does believe in the bleeding having been vicarious to ordinary menstruation."

It will be seen that the case has striking features of similarity to one which I reported in the ARCHIVES a few months ago, in which a young lady had deep bleeding fissures in the palms and soles. She also was certainly hysterical in a high degree, but it seemed almost beyond possibility that she could have voluntarily produced the conditions which were present.

If any of my readers can give information as to the present condition of Dr. Barnes' patient, both he and I would be very glad to receive it.

I have failed to find Dr. White's address.

NOTES ON CANCER AND CANCEROUS PROCESSES.

The propositions in reference to cancer which I am chiefly concerned to maintain, are—*First*, that it is a modification of chronic inflammation, and that the same laws which are applicable to the one are, for the most part, applicable to the other. *Second*, that it is under the influence firstly of inherited tendency and secondly of senility, that processes inflammatory in their outset tend to pass into those of cancer. *Third*, that cancerous processes are in their initiation local, and that the disease becomes constitutional by infection by elements derived from the primary growth.

In connection with the pathological doctrines just indicated, certain groups of rare cases in which cancer occurs in some sense as a complication of other forms of disease become of great interest. Thus, in Kaposi's disease we have first freckles, then ulcerations with granulation growth, and lastly a form of epithelial cancer. In granuloma fungoides, or in the various maladies which are put together under that name, we have an early stage sometimes not distinguishable from Eczema, whilst the later ones are undoubtedly malignant. The affections which it is the custom now to class as sarcoma of the skin, are some of them not easily distinguishable in the first, nor possibly even in any, stage from forms of chronic inflammation. The general bearing of such facts seems to be strongly in favour of the belief that, given certain individual proclivities, inflammation may slide into cancer. We may note, in passing, that when it does so, it is usually under the influence of approaching senility.

On Lupus-Cancer.

I purpose on the present occasion to record a few facts in reference to the tendency of Lupus to take on malignant action. There is nothing novel in the assertion that it

PLATE XXI.

LUPUS-CANCER.

This portrait shows the occurrence of epithelial cancer in the scar of lupus. The patient was a woman aged fifty-one, who had suffered from lupus of the face for about thirty years. In the scar of the lupus on the upper lip malignant ulceration had occurred about a year before I saw her. I excised the lip in October, 1873, making a free incision into the cheek in order to bring the parts together without tension. It healed soundly, but within six months another patch of malignant ulceration developed in the scar of the cheek at some distance from the original one. Chloride of zinc was now applied, but after a short time she declined further treatment. I believe that she died of the disease within a year of the commencement of the cancer.

I have seen several cases like this in which cancer attacked the scar left by lupus, and in all it proved rapidly aggressive. The microscope showed only the usual conditions of epithelial cancer, but the disease conformed to the type of rodent cancer in this, that it did not produce any disease of glands. In rapidity of progress it was, however, in marked contrast with what is usual in rodent cancer, destroying the parts widely and deeply.

See page 124.

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See page 124.

West, Newman chromo

occasionally does so.* Many observers have noted the fact and recorded examples of it. The observations which have been made respecting it have been tolerably uniform. It would appear that the change of process usually takes place late in the case. The lupus patch has probably been present many years before it takes on cancer. In other words, the patient has made definite advances towards senility. The cancerous action usually begins at the edge of the lupus patch, and in a part which was ulcerated and granulating. When once set going the cancerous action is somewhat rapid. It develops quickly a large sprouting mass, and it is remarkably resistant of all treatment. If destroyed by escharrotics it sprouts again, and if excised, however freely, it is not long before a new growth demands fresh treatment. Such, at least, has been my own experience of what we may suitably call Lupus-cancer. It is, no doubt, a variety of epithelial—in this all those who have made microscopic investigation agree—but it is far more rapid in its spreading than is that form of epithelial, the rodent ulcer, which usually attacks the face. Whether it has any tendency to infect the lymphatic glands I do not know for certain. The cases which I have myself observed have been only few in number, and have ended fatally by local extension without, so far as I am aware, any implication of the glands. I have seen fragments of possibly near a dozen examples, but of only two am I able to recall the particulars in which I traced the case to the end. Nor in either of these two did I really see the patient myself during the last few months of life. These circumstances make it more difficult to speak with confidence as to gland implication than might have otherwise been the case. I think, however, that we may safely assume that although so different from "Rodent" in its rapidity and in the tendency to fungate, Lupus-cancer yet conforms to the rule so all but invariable in rodent of not causing gland disease. In the tendency to produce a prominent fungating mass it resembles what we see in Kaposi's disease. In the latter, however, I believe that there

* Royer, Devergne, Bardleben, O. Weber, Hebra, Kaposi, and Volkmann have all published examples of it.

is a far less degree of malignancy, the growth not passing deeply and being readily cured by local measures. If the reader will compare the portrait which I have given (Plate XXI.) with those which I copy from Bayha (Plate LXII.), and those of the latter one with another, he will see that what I have asserted as to tendency to fungate is fully borne out.

In reference to the production of carcinoma in the scars of lupus, it is of great interest to note that Dr. Sangster and other observers have recorded that even in cases where nothing like cancer was present, the malpighian layer yet showed a remarkable tendency to send processes deeply into the diseased corium. Such facts favour the opinion above expressed that processes of common inflammation may be attended by a simulation of those of cancer, and with probably in the end a decided tendency to its reality. I do not think that we shall be right if we simply regard Lupus-cancer as cancer of scar-tissue. To some extent it may be so, but not I think usually. Cancerous processes taking origin in a healthy scar, such for instance as that of a burn, are, I believe, often very slow in progress. They run a course very different from that of Lupus-cancer, which is usually acutely malignant. Mr. Cæsar Hawkins, who first noted the peculiarities of cancer of cicatrix, held that usually the glands did not become affected. It is not improbable that we must recognize some varieties in Lupus-cancer, these being determined by the precise tissue in which the process begins. In some it begins in parts still affected by lupus-growth, in others in tissue more or less closely approaching to sound scar, and in yet others it does not begin either in scar or in lupus tissue, but only in parts adjacent to them. The facts illustrating the latter are, I must admit, only few, but they are sufficient to suggest that there is a bond of connection between lupus and cancer more close than would be indicated by regarding all cancer occurring in such association as simply cancer of scar.

I will record briefly the notes of a few cases with exceptional features.

Lupus of old standing—Rodent Ulcer in the same side, but not continuous.

A lady of about 45, Miss ——, whom I had long had under observation for a patch of common lupus in her left cheek, had an ulcer form in the healthy skin beneath the inner angle of the eye on the same side. This ulcer was a well-characterized rodent or superficial form of epithelial cancer. There was a considerable width of healthy skin between it and the lupus patch.

Lupus-Cancer in an old-standing Lupus Patch on the face—Epithelial Cancer near anus.

In another instance lupus-cancer attacked the lupus patch, and simultaneously a cancer of another type developed on a distant part. This case is one of the most important examples of cancer following lupus which has come under my observation. Mr. K——, of Farnham, was about 56 years of age, and had suffered for upwards of thirty years from lupus of his face when he came under my treatment. He then had a fungating growth of cancer in the middle of a lupus patch on his left cheek. I destroyed this with chloride of zinc paste several times, but only with temporary success. At length, the bone having become implicated, I did a severe operation, cutting away all the anterior part of the upper jaw, and at the same time removing soft parts most freely. At the time that this operation was performed he showed me for the first time a growth of epithelial cancer on the skin between the coccyx and the anus. It had the characters of rodent ulcer, and had been present, he said, more than a year. Mr. K—— died about nine months after my last operation with a return of the growth on the face. In him, as in many other patients, we witness the influence of senility in disposing towards cancer.

Lupus followed by Rodent Ulcer (Cancer).

A gentleman, aged 34, was sent to me who had been for ten years under treatment for lupus on his right cheek. It had been repeatedly scraped and cauterised. The lupus had remained a single patch in the middle of the cheek. The

final condition, and that for which he came to me, was a scar with characteristic semi-transparent nodules and crescentic rolls of rodent ulcer. There was no family history of either consumption or cancer.*

Epithelial Cancer in the Scar of Lupus-erythematosus—Excision —Return near, but not in the scar.

A young woman who was the subject of Lupus-erythematosus came under my care at the London Hospital in 1882, with a hard-edged ulcer on the left temple which had developed on the lupus patch. It was clearly malignant, and Mr. Waren Tay was kind enough to excise it for me. It healed soundly, and when the patient was next seen about two years later (February, 1884), the scar remained sound. At this latter date another ulcer had developed at a little distance from the scar. On both occasions Mr. Tay examined the excised parts with the microscope, and he informed me that the characters of epithelial cancer in its ordinary form were definite, there being among other conditions abundance of nested cells.

Mr. Nayler's case.

Mr. Nayler records a case of cancer following lupus in a man aged 38, who had for years been under Mr. Startin's care. A fungatory growth as large as a walnut was developed, and had passed through the cheek into the mouth. It was freely excised by Mr. Pollock. Six months after the healing there was no return.†

Abstract of report by Dr. Bayha on Lupus-carcinoma (with lithograph).

In an important report on Lupus-carcinoma, published in Brün's "Beitrage," 1887, Dr. Bayha, of Tübingen, has

* I have seen several cases of cancer in lupus patients in which the two processes were probably quite independent of each other, unless, indeed, we accept them as implying a common constitutional proclivity. In one of these a lady, Mrs. E——, æt. 38, who had long been a sufferer from lupus of the face, came to me with cancer in one breast.

† Nayler on "Skin Diseases," p. 173.

Fig. 1.

Fig. 2.

Fig 3.

Fig 4.

Cancer following Lupus.
(Copied from Dr. Bayha.)

West, Newman, lith.

recorded, not only his own experience, but has given a valuable summary of our knowledge on the subject.

Including five cases of the supervention of carcinoma in lupus or lupus-scar observed at the Tübingen Clinic, Dr. Bayha has found record of forty-two. Eleven of these were cases in which the lupus had been healed for a longer or shorter time, and the only special points to notice in them were the rapid progress of the ulceration (great malignity), and that in one case carcinoma supervened as early as the twenty-sixth year.

The following are the brief details respecting the five cases observed by Dr. Bayha himself. Four of these are illustrated in Plate LXII.:—

Cases.—1. Johann H——, aged 28. Lupus of face since age of ten years. Epithelioma of the right cheek in July, 1869.

Death June, 1871. No secondary deposits found on post-mortem.

2. Bernhard L——, aged 62, had lupus of the right cheek for forty years. In 1860 epithelioma supervened.

3. Christian H——, aged 41, lupus since 14 of the nose, cheeks, and right upper eyelid. Epithelioma developed in the right side of the upper lip.

4. Pauline D——, aged 28. Lupus of left cheek since age of five, soon spreading to rest of face and neck. Epithelioma supervened in the cheek; it was healed with the cautery and iodoform. It grew rapidly, but the patient's death appeared to be due to iodoform poisoning. At the post-mortem, hæmorrhagic infarcts were found in the spleen and other organs.

5. Christiane M——, aged 36. Lupus of right cheek and of forehead since age of sixteen. Epithelioma of the cheek in 1881, excised; recurrence in temple in spring of 1885, removed with the cautery; recurrence soon afterwards. After a further operation the wound cicatrized rapidly.

Dr. Bayha draws attention to the early age at which cancer sometimes develops in lupus. Thus four cases occurred under thirty years, and three others under forty. Its site was in eleven the cheeks, in four the upper lip, in two the

temporal region, whilst in two it was observed in two positions simultaneously (the cheek and nose, and the cheek and breast). In most cases the lupus had existed over ten years before the supervention of cancer. Its frightfully malignant tendency was, as he remarks, shown by the fact that out of ten patients in whom the growth was excised, seven died shortly afterwards of recurrence, and only one appeared to be cured.

The following is a brief summary of Dr. Bayha's remarks respecting the pathological nature of Lupus-carcinoma :—

In the more numerous and interesting cases in which epithelioma developed in a part then the seat of lupus, the irritation of the cell-deposit and the abnormal vascularity may be considered as having had some share in its causation—just as soot and paraffin acting as persistent irritants have been shown to possess, or as a long-standing "psoriasis linguæ" is admitted to have. Further, the inter-papillary prolongations of epithelium which occur in cases of common lupus (as shown, for instance, in cases described by Lang and Hopin) must be regarded as favouring its development. Busch has described this down-growth of epithelium with formation of epithelial-nests in the prolongations, and has pointed out that it is nevertheless not true cancer, and in most cases follows the chronic course of ordinary lupus. He termed it "epithelioma-like lupus." In sections from the real cancerous growths the prolongations were seen to branch up, and their epithelial cells, becoming smaller, to intermingle with the round cells of the lupus deposit.

DISEASES OF THE EYE.

No. V.—*Double Optic Neuritis rapidly passing into complete blindness—Patient a robust man whose relatives were gouty, but who had not himself suffered—Severe headaches the only concomitant symptom—Recovery with white discs but fair vision—Record of state four years afterwards.*

On May 25, 1886, I saw, with Dr. Foreman, of the Stoke Newington Road, a very interesting case of double optic neuritis for which we could assign no other cause than that it was probably in association with gout. Our patient was a retired builder, aged 50, who had been accustomed all his life to eat largely, and to take beer pretty freely. He had never been intemperate, and had enjoyed excellent health. He had never himself had any single gouty symptom, but he was a florid stout man, and his father and one of his uncles had suffered very severely from ordinary paroxysmal gout. When I saw Mr. P—— he appeared to be in good health, and excepting that he was quite blind he had no symptom of any derangement of function. His blindness had been about three weeks coming on, and the only exception to its completeness was that he could just recognize a candle-flame held to the temporal side of his left eye. His pupils were widely dilated with atropine. There was not the slightest dulness of the media, nor any congestion of the eyeballs. With the opthalmoscope both discs were seen to be somewhat swollen, and their margins hazy. The changes were most definite, but they were not extreme, and did not approach the condition of "choked disc." The history of his illness was as follows: On the 22nd of April,

that is nearly five weeks before my visit, he had complained of being chilly, and of having "caught cold." He continued to go about as usual during the next fortnight, but had some cough and aching in the limbs. At the end of this time his cold left him, and he began to suffer from shooting pains in his eyes, temples and forehead. For these he consulted Dr. Foreman, and the diagnosis was "Neuralgia." The pains were sharp and shooting, and would come and go. They often woke him in the night, but never really made him sleepless. As they were attended by considerable intolerance of light he was kept to a dark room, and atropine was used. Under these conditions it naturally happened that there was no exact appreciation of the time when his sight began to fail. When his headache ceased and light was admitted to his room it was found that he was practically blind. This was only three days before I saw him. Probably the failure of sight had been in progress for about three weeks, for his wife remembered that once while in chapel he had put down the book because it made his head ache. The right eye had failed before the left, and the pain had been chiefly in it. The pain in the temples had suddenly ceased after a blister, and with its cessation the failure of sight had become nearly complete.

The subjective symptoms, with the exception of headache, had been exceedingly slight. He had had no flashes of light, and had scarcely noticed that his sight was failing until he was blind. Probably this was in part to be explained by the fact that one eye failed before the other, but chiefly because his headache and intolerance of light prevented him testing his sight. He had scarcely even noticed that he was in fog.

We prescribed mercury in small and frequently repeated doses with the intention of inducing ptyalism rapidly.

On June 11th, three weeks after the first visit, I again saw Dr. Foreman's patient at his own house. The gums had been decidedly sore for the last four days. He has been kept in the house under a diet chiefly of slops. Although he complains of feeling very weak there are no symptoms of ill-health, and were it not for his blindness he would be quite

well. His left eye, with which at the last visit he could see a little at the extreme temporal side, is now quite blind. I could scarcely get him to tell when the hand passed in front of a candle-flame, held close in front. His right eye, which at the date of last visit was utterly blind, is now beginning to improve, and he can count fingers with it. He has not the least headache. We decide to continue the mercury, but in less frequent doses.

In October he called on me at my house, and I made the following note:

He looks and feels perfectly well. He can just puzzle out 20 at 10″. The two eyes are much alike.

He has been to Ramsgate, and has taken his ale again, and has got quite strong again. No medicine has been given for twelve weeks past.

After this note I did not see Mr. P—— again for three years. In January of 1889 Mr. Foreman wrote to me, and reported him in good health and seeing fairly well.

In April of the present year (1890), Mr. P—— called upon me in the hope that I could order spectacles for him. I made the following notes:

He is now aged 54. He sees $\frac{2}{5}\frac{0}{0}$ with R, $\frac{2}{0}\frac{0}{0}$ with L, reads without glasses only 16. He has been in perfect health since I saw him. He now comes hoping for spectacles. His fields are somewhat limited in their outer parts. He can see to write his name, and can make it out when written. The optic discs are almost as white as white paper. They are quite clean, and the retinal vessels upon them are of full size. I cannot appreciate any material shelving of the disc, nor see the cribriform fascia very distinctly. The left disc is uniformly pale in all parts; the right shows a difference, the inner two-thirds being less pale than the third next the yellow spot. There are no retinal or choroidal changes whatever, and the margins of the discs are distinct. The pupils are in all respects normal.

Comments.—The above case is one of an important class which as yet our Ophthalmic text-books have scarcely recognized. We have in it an example of acute optic neuritis without obvious cause, and without any concomitants as

regards other disorder of the nervous system or of the general health. As a period of four years has passed and the health is still good, we may feel confident that no serious organic disease is present within the cranium. It may seem to be an easy resource to diagnose gout, yet I confess that I see little else to suggest. That gout does cause peripheral neuritis, as for instance in the case of sciatica and brachyalgia and many forms of neuralgia, there can, I think, be but little doubt. Was the case one in which the optic nerves were affected in a manner similar to what the sciatic suffers in sciatica? The patient had gouty relatives, and had lived in a manner likely to produce it. I may note, however, that if we diagnose it as gout, the diet test wholly fails us. The patient had been accustomed to take beer pretty freely, and never had found that it disagreed with him. He had never noticed that his urine became thick.

No. VI.—*Loss of Sight in one eye only—Diagnosis of gouty neuritis, but without any history of gout.*

A farmer from S—— came to me on the 24th of March on account of blindness of his right eye. The pupil was widely dilated, No. 14 at least, and it only moved in a very slight degree on suddenly exposing its fellow. The left eye was perfect, but with the right he could not see the windows, and had no perception of shadow when the hand was passed in front of it. He was a stout, florid, very healthy-looking man. No sort of illness had preceded the failure of sight. He gave a graphic account of the progress of the attack. Just one week before I saw him, on a Thursday, he felt a slight pain across the right eyebrow. This was attended by some running of tears, and then he found that the eye was dim. After these symptoms had lasted a few hours he went to look in the glass, and found his pupil much enlarged. On the following day, Friday, he could still see large objects. On Saturday he could not see anything straight before him with the affected eye, but could dimly see things on all sides. On Sunday he was quite unable to see anything, and had

remained so since. On ophthalmoscopic examination I found the edges of the optic disc concealed at all parts excepting immediately opposite the yellow spot. At this part they were perfectly clear. There was no great swelling of the disc, and the changes did not extend far into the retina. The artery was of good size, and the veins turgid. In the other eye there were no morbid changes, excepting a small patch of opaque nerve-fibres below the disc. Mr. R—— complained that in this eye he had very similar feelings to those which preceded the loss of the other—with pain in the brow, &c. On careful inquiry it did not appear that he had had any headache or other indications of cerebral disease. He said that sore throats had been prevalent in his neighbourhood and that he had had a slight one.

Mr. R—— came to me again on May the 25th. During the interval he had taken mercury, and had his gums very sore. He also had abstained entirely from stimulants. His eye remained quite blind, and there had been no further symptoms threatening the other. I now found his disc decidedly pale, especially on the side next the yellow spot. It was slightly swollen, and its edge was indistinct on the temporal two-thirds (inverted image). Thus there had certainly been a descending neuritis. He was in all respects in excellent health, though he was much pulled down by low diet, &c. He had no headache whatever. His pupils were now of equal size, and not larger than No. 3 when exposed to the light. The pupil of the blind eye dilated when the other was covered, but not to larger than No. 7. It remained at this size, and uninfluenced by sudden exposure or shading. It appeared to be possible that the observation as to the early dilatation of the pupil in the former note was an error, and that it might have been due to atropine. He insisted, however, that his statement was correct, and that he had noticed the dilatation before he saw his surgeon or used any application. His wife thought otherwise. His aspect is quite that of a gouty subject, but he still insists that there is no gout in the family.

Comments.—In this case, as the preceding one, an interval of several years has elapsed since the attack of neuritis, and

the patient remains in good health. The cases differ in that in one both eyes were affected, and a good degree of recovery took place; whilst in the other only one eye suffered, and it remained permanently blind. In both the patient was an adult man of gouty aspect, but without any history of gout.

No. VII.—*Blindness of one eye only with white disc —History of so-called "sun-stroke" ten years ago with paresis of several nerves in same orbit —No aggressive nerve disease.*

The following case is only a fragment. I had seen its subject, in the first instance, ten years before the notes now published were taken, but have been unable to find any record of my first observations. Its value consists in its being an example of one-sided optic neuritis with blindness of the affected eye, and without any tendency to aggressive changes in the nervous system. As such it may be placed in company with the preceding one, and both may help to the formation of rules of prognosis.

Abraham Brownhill, aged 45, a machinist on railway. He states that I saw him ten years ago for loss of the sight in his left eye. It was "from sunstroke." He was then living at Wellingborough.

At the present date the right eye remains perfect, whilst the left is still quite blind. The pupils are of equal size, but the left dilates when the right is covered. He complains that there is often a heavy pain in the back of his head. If he remains too long in bed, as on Sunday mornings, it always brings on headache. He has had no illness during the last ten years, except once, "a touch of pleurisy." He suffers from eczema in his legs, which is the cause of his now again coming under care. He has no other nerve symptoms.

He says that, on the former occasion, I said to the pupils present that the first, third, and sixth nerves were all involved, and he remembers that he had lost smell and taste. The disc is now uniformly white, but the central vessels are of normal size. The whiteness has a slightly dirty grey tint.

There are one or two tags of iritic adhesion, but they do not interfere with the action of the pupil.

The eyelid does not now droop, and he can move the eye in any direction. The eyeball is decidedly a little prominent.

He is not liable to worse headaches than formerly. They never lay him up. He is "often dizzy," and "walks sideways at times." This occurs at intervals of months or years.

His smell and taste, which were lost, have quite recovered. His hearing is perfect, and never was impaired.

Remarks.—I have given the patient's name in the above narrative on the chance that some of my readers may perhaps be able to assist me as regards the sequel. It is several years since my notes were written. I believe that there was no history of syphilis, but upon this point I regret that my notes give no information.

No. VIII.—*Symmetrical Amaurosis occurring quite suddenly in a smoker exposed to much heat, and persistent for seven years without alteration.*

It fell to my lot on September 28, 1877, to have to examine, in reference to a Government pension, a robust-looking man aged 40, who had formerly been in the navy. Almost accidentally I discovered that his sight was very defective, and on further inquiry learned that he had been disabled by it for six or seven years past. Yet during that time no other nerve-symptoms had shown themselves, and as stated, he appeared in perfect health. It became, therefore, of much interest to ascertain what was the nature of his amaurosis.

His failure was equal in the two eyes, and he could see only $\frac{2}{70}$. His pupils were sluggish. The optic discs were pale, but not much atrophied, and the central vessels kept their normal size. The pallor was not greater on the side next the yellow spot as is usual in tobacco cases, but the symmetry of the condition suggested that cause. The man had experienced no failure of sexual power, and his wife had borne him ten children in eight years.

His history of the failure of sight was that it occurred suddenly. He was at the time serving on ship-board in the

tropics, and exposed to extreme heat. He went to sleep one night quite well, and in the morning awoke with headache across the forehead and great dimness of sight. He believes that his sight was as bad then as it is now. He was under medical care for some days on account of the headache, and after a time he regained perfect health, his eyes remaining, however, as at first. He was smoking at the time this happened, and had continued to do so ever since, but not in any excess. He denied having ever had syphilis. At the time of my examination of him he was not by any means clear in his statements, but I could not get him to deviate much from the above account that he lost his sight in a single night, and that he had never since been either better or worse. The only difference that he had noticed was that at first he saw much mist, and now he simply could not see clearly. I have in several other cases had a similar history given me of sudden failure, and in most cases the patient was at the time much exposed to heat and sun-glare. I have not, however, been able to obtain in any of them a history extending over so long a period. In several closely parallel cases improvement took place at once on disuse of tobacco. It is quite possible that we have in this case an example of tobacco-amaurosis remaining stationary, but it is an exceptional case, for I believe they almost always get either better or worse—better if the tobacco be left off, and worse if, as in this instance, it be continued.

No. IX.—*Acute Neuro-retinitis after a severe illness—Retinal conditions much like those of Albuminuria — No albumen found — Recovery with blindness—Absence of Menstruation.*

Amongst the cases which bear with great interest upon the question of prognosis in optic neuritis is that of a girl aged 10, who was brought to me by Dr. Brett, of Watford, in 1879. Her eyes presented very extensive and conspicuous evidences of neuro-retinitis. The discs were swollen, elevated and hazy. The trunks of the large vessels were in parts buried, and the edges of the choroid were very extensively

concealed. The large veins were exceedingly tortuous and very full. Near to the yellow spot in both was a group of very white streaks and dots, the arrangement of which was peculiar and not exactly like that seen in albumenuria. The streaks did not radiate from centres, but began from a base-line much like a touch of a greasy finger sideways on glass. The mixture of dots and streaks was also a peculiarity, and further the streaks were not lines of equal width in all parts, but rather microscopic lagoons. The appearance might be compared to quicksilver spilt on paper and arranging itself in globules of various sizes, with some streaks interspersed. I do not know of any published portrait which represents accurately this arrangement. Jäger's 27th Tael reminds me of it a little, but is on far too gross a scale. I may just mention that I sent Miss G—— to my friend Mr. Nettleship for his inspection, and he declared that the white streaks were indistinguishable from those of albumenuria.* In some minor points, as I have just said, they were, I think, distinguishable; still, I admit their similarity was close. There were no hæmorrhages but extensive tracts of the retina were hazy. Thus then it will be seen that we had neuro-retinitis with deposits resembling those of renal disease. Let us now turn to the history of the case, and see if it fitted with such a diagnosis. Dr. Brett told me that he had repeatedly examined the urine and had never found albumen, and, further, the history pointed clearly to brain disease as the starting point. Our patient was of healthy family, and until her present illness had herself been robust and very active. Her illness began in March (that is seven months before I saw her), and the first symptoms were feverishness and headache. These were at first thought to be due to biliousness, but after a few days it became evident that there was something much more serious. Sickness set in and there was most obstinate constipation. Headache never became

* Mr. Nettleship wrote:—"I have just seen the girl with Dr. Brett, and am much obliged for the opportunity. Intense neuro-retinitis with great swelling of discs, and numerous white patches near Y. S. indistinguishable from results of albuminuric retinitis. The state of the discs and extreme tortuosity of vessels would of course lead one to suspect that it had been essentially a cerebral case and not a renal case with cerebral symptoms. Everything is worst in right eye."

very severe, but after ten days or so coma came on, and she lay for nearly a fortnight quite insensible and daily expected to die. During this time her urine and fæces passed involuntarily, and she also had squint. Under vigorous treatment by mercury and iodide she at length recovered; but the squint continued, and her sight was found to be defective. From this time forward she never used her sight for reading. It was uncertain as to the precise extent of defect, as no tests were used; but until a month before she came to me it was supposed that she saw fairly well with the left eye.

From the above facts it will be seen that the loss of the function of sight continued after recovery as regards the brain had well set in, and it was still (six months afterwards) advancing. The girl had been sent to the seaside; she had recovered almost her usual state of health, was free from headache and had all her other special senses perfect, and yet her sight continued to fail. I might have said that her pupils were large, and that of the right eye larger than the other; both were sluggish, and the right almost motionless. I inquired particularly as to the state of the brain, and was told that at first it was feared she might pass into idiotcy, but that now she had no indications of mental weakness. Her temper, memory, &c., were as good as before.

Under what name are we to place the illness through which this child had passed? The diagnosis of tubercular meningitis was offered at the time, and I think it will be agreed that it was the most probable. But when recovery took place doubts were felt. The old name "cerebral fever" might be used, but it implies nothing that is definite. Was it an attack of inflammation of the subarachnoid spaces at the base of the brain, not of a tubercular character and therefore amenable to mercurial treatment? In connexion with optic atrophy after neuritis and severe cerebral illness I have often received a precisely similar history. I have been obliged to believe that there is a form of illness not to be distinguished at the time from tubercular meningitis, which is yet not exactly of that nature. If it be such, then tubercular meningitis may be recovered from and its subject may remain

perfectly well for indefinite periods afterwards, often, however, wholly or partially blind. The blindness in most cases is present from the first. I have often in such cases seen, in addition to the optic atrophy, white spots grouped near the macula, and have sometimes compared their appearance to that of spider's eggs. Whether the subjects of such cases remain well through many years afterwards is more than I can say; but I have certainly seen several in which every trace of disease had disappeared and the good health was continued at periods varying from one to four or five years afterwards. In one case in which I was interested, a girl of fourteen or fifteen who had been admitted into a blind school died four or five years after the cerebral attack of an illness which was, I believe, supposed to be tubercular.

The subsequent progress of this patient may be briefly stated. She has remained blind, but has not developed other cerebral symptoms. In 1881 Dr. Brett wrote to me that she could just distinguish shadows, but not objects. Her general health was very good, and she had learned to knit. In 1884 Dr. Brett was again good enough to report, and much to the same effect. Our patient was now twenty years of age and had never menstruated. In an elder sister (23) a like failure of the menstrual function had occurred and was associated with weakness and pallor. Their brothers (ten) were in good health.

Quite recently (1890) I have again heard from Dr. Brett, who takes a most kind interest in the case. It is now eleven years since the illness, and the young woman's condition is much as it was. She is nearly blind, but in good general health. She has never menstruated.

No. X.—*Gout and Syphilis—Spontaneous Gonorrhœa — Unsymmetrical Retinitis Pigmentosa probably of syphilitic origin.*

The following case possesses several distinct features of interest. The patient was the subject of both gout and syphilis. He afforded an example of that peculiar form of spontaneous gonorrhœa to which gouty persons are some-

times liable. He had suffered much from recurring iritis, which no doubt was again gouty. He was the subject of the peculiar serpiginous patches in the glans penis which I described in the last number of the ARCHIVES. These were of a syphilitic lupoid nature. He had also patchy sclerosis of the tongue, in part syphilitic, and in part due to smoking. Lastly—and this is the feature of most interest—he was the subject of retinitis pigmentosa and posterior polar cataract in one eye only. The want of symmetry takes the case out of the category of ordinary retinitis pigmentosa (which is always symmetrical). The form which occurs in the subjects of syphilis, whether inherited or acquired, is on the contrary almost always non-symmetrical. It is an imitation of the type form but with differences. As an example of this I incline to claim the present case.

Mr. B—— age 56, whom I had seen a year before for gouty iritis, came to me on August 11, 1873, for profuse discharge of pus from the urethra which had lasted three weeks. There was no scalding whatever. Twelve years ago his eyes had been attacked by iritis, and he had had many attacks in them. Two very bad attacks were in the right eye. The sight in the right eye has been reduced to mere perception of light; but with the left eye he can read well. Since I last saw him a year ago, he has had recurring eruptions in various places. He has now some serpiginous patches on the glans penis, and his tongue is sore with large white patches. There is unsymmetrical retinitis pigmentosa. The retina of the right eye is covered with specks and patches of black pigment; these are very numerous and confluent in places. They are more plentiful at the periphery, but come up to the disc margins. There is no absorption of the choroid. There is also slight posterior polar cataract. The disc is waxy and grey, and the vessels are reduced to the smallest possible threads. It is fifteen years since he first consulted a doctor about his eye. It had, however, been failing slowly for some years before that; at the time of the great comet (1857), he remembers that he had been kept in one room by the state of his right eye for three weeks This probably gives the date of the first attack of retinitis.

Mr. B—— at the time that the above notes were taken was about 56 years of age. He had suffered from syphilis in early life, and had had much irregular treatment for recurrent symptoms chiefly affecting his tongue and skin. He was still in fair health. I regret that I cannot complete his case, as I have been unable to find any more recent notes.

No. XI.—*Changes characteristic of Choroido-retinitis in one Eye only, consequent on a very severe contusion of the Eyeball fourteen years previously.*

I. W——, aged 31, a florid man with red hair, came to the Blackfriars Hospital in 1874 for sycosis tarsi. Having been told that his left eye was almost blind (being unable to count fingers), I made an examination, and a somewhat unusual condition of things was discovered. There were numerous very thin filmy opacities in the vitreous, exactly like the wings of insects. In the retina were numerous coal-black pigment deposits, forming small, nearly round patches looking, in the inverted image, about as large as pins' heads. They were present in almost all parts, and nowhere did they assume the delicate lines or branching forms which occur in true retinitis pigmentosa.

He believed that it had all resulted from a blow received fourteen years before. He was kicked violently by a horse, and afterwards the eyelids and adjacent parts swelled up very much; and from the day of the accident he had never seen better than he could on admission. The other eye was perfect and free from pigment deposits. He denied ever having had syphilis, and it seems most probable that his own impression as to the cause was correct.

In connection with this subject I may refer to a paper by my eldest son at page 120 of Vol. IX. of the Transactions of the Ophthalmological Society. He reports a case, with ophthalmoscopic portrait, and gives a *résumé* of our knowledge as to the effect of blows in the eye in causing choroido-retinal pigmentation.

No. XII.—*On changes in the Eye in connection with Senility.*

In Mr. H——'s case it was of interest to note that changes had occurred in different textures of the eye simultaneously. Thus there were striæ of opacity in the lens, changes at the yellow spots, and great pallor of the discs. The conditions were quite symmetrical. There could be little or no doubt that they were due to senility and senility only, for Mr. H—— was a very healthy man, of temperate habits, and in good general preservation for his years. His age was 79. He walked erect, had an excellent memory, and was still accustomed to come from his country residence to his city office once a week. It was his special senses only which were failing him. He was becoming both deaf and blind. It is not without interest to note that his wife, who was within a year of his own age and in equally good health, was losing her hearing gradually in exactly the same way as her husband. As yet, however, her eyes served her well. There was yet another fact to be observed illustrating, I think, a not uncommon difference in senility in the two sexes. Whilst Mr. H—— had become thin and dry-fibred, retaining good colour, Mrs. H—— was fat, flabby, and pale, looking almost like the subject of myxœdema.

To describe the changes in Mr. H——'s eyes, I may say that they consisted in peripheral lines of opacity in the lenses; in great general pallor of the optic discs, and in absorption changes at the yellow spots. The latter consisted in the production of groups of whitish patches of considerable size, and of roundish or irregular forms. These were placed exactly at the yellow spot in each eye, and were limited to these regions. They were much larger in size and more restricted in position than are the little white dots so frequently seen in the form of senile choroiditis known as Tay's Amaurosis.

The whole subject of senile changes in the eye seems worthy of more systematic study than has yet been given to it. We have long recognized various forms of opacity of the lens (senile cataract), but respecting the white atrophy of the

optic nerve and different types of choroido-retinitis which occur to the aged we know but little with any precision.

No. XIII.—*Case illustrating prognosis in reference to hereditary syphilitic affections of the eye—Very extensive Choroido-retinitis with waxy discs.*

Miss M-——'s eyes illustrate some very important points in reference to the choroido-retinitis due to inherited syphilis. They show its unequal severity in the two eyes, its absolute arrest, and the possibility of fair vision being retained in a much damaged organ. Miss M—— pursues with much industry and some success, the pursuit of an artist, yet one eye is quite blind, and the other has suffered severely from choroido-retinitis and is constantly affected by nystagmus.

Miss M—— has a sunken nose and deformed physiognomy. All her teeth are dwarfed, and the upper incisors characteristically screwdriver-shaped. She believes that her left eye has been blind from infancy. She had "a grey cataract in it." This was removed by needling some six or eight years ago, and we can now, through holes in the capsule which remains, see the choroid. There is literally not a single portion of it which has escaped disorganization; everywhere it presents masses of pigment accumulation and streaks of exposed sclerotic. The disc is pale and waxy and the arteries extremely small. In the other eye the disc is, though in much less degree, pale and waxy, and the retinal vessels are decidedly diminished. Near to the disc there are ill-defined patches where the hexagonal layer is absorbed and pigment accumulations are seen. In the periphery and also at other parts are many minute lines and streaks of pigment, like those of retinitis pigmentosa. The eyeball oscillates so much that minute inspection is difficult.

Miss M—— tells me that about eight years ago she was for four months so far blind that she could only just tell light and strong colours. At this time she had much pain in her eyes, and probably she went through an attack of keratitis. Her evidence is clear that for some years, in spite of close

work, the right eye has got no worse. She is under my care now for a form of epilepsy.

No. XIV. — *Chronic Conjunctivitis and Ulcers on Corneæ in association with psoriasis—Psoriasis sixteen years—Inflammation of Eyes three years —Probable influence of exposure to fire heat.*

A disease to which the name "Pemphigus of the Conjunctiva" has been given is well known, and during recent sessions has excited considerable interest at the Ophthalmological Society, several interesting examples of it having been brought before the society by Mr. Lang and others. In that disease the conjunctival sac becomes gradually obliterated after repeated attacks of inflammation. The mucous membrane itself does not usually show bullæ, and the name Pemphigus becomes appropriate only because the patient usually presents some form of skin disease attended by vesication. It is, I think, but seldom, however, that the eruption is a well-pronounced pemphigus. A case which I have now to relate is of great interest in connexion with the malady to which I have referred. It gives strong support to the belief that there are conditions of dermatitis which may be attended by disease of the conjunctival sac. The skin affection, however, was not bullous, but a well characterized psoriasis. My patient was a man named G——, aged 48, who was sent to me by Mr. Harrison, a very able surgeon at Braintree. He was in good health, but had suffered for many years from psoriasis. His face was much disfigured by what appeared at first to be very severe lippitudo. The lower eyelids were everted, and a rim of red swollen conjunctiva exposed. On close inspection it was seen that the eyelashes were not themselves involved in either the upper or lower lid. They had not been destroyed, but were simply displaced by the swelling and eversion of the lid. The conjunctiva was thickened and vascular, and the lower palpable sac was entirely obliterated. The thickening of the membrane on the globe was in fan-shaped bands, resembling ill-marked pterygia. These false pterygia had their apices near the centre of the cornea, and

the surface of the latter was ulcerated where vascular. The upper palpebral sulcus was not much affected. Near the centre of each cornea were several hazy ulcerations. The condition of the two eyes was much alike. The state of the man's tongue gave support to the belief that there was a tendency to inflammation of the mucous membranes in connection with the constitutional cause, and that the state of the eyes was not due either to the arsenic which had been taken for the psoriasis, or to any accidental or local cause. The tongue showed red abraded patches, which were arranged chiefly on its sides. The patch on the left extended nearly to the middle. The nails also were affected. They were inflamed at their roots and edges, and had become roughened. The skin disease was an inflamed psoriasis, severe and very copious on the backs of the hands, but occurring also all over the limbs, trunk, and head. In some places its patches were polished and smooth like lichen planus, but for the most part it conformed to the type of common psoriasis. No special diathesis could be traced in the patient. The psoriasis patches showed a tendency to contract and make the skin tight, and on the backs of the hands were many cracks. Patches of ordinary psoriasis occurred on the tips of the elbows and on the knees.

Mr. Harrison wrote to me that arsenic had been repeatedly given, and over long periods, and had not appeared to do good. The eyes had been very painful, and the skin used to smart much were the fissures were. His occupation was that of baker and confectioner, and the heat of the fire had probably made his hands and face worse. It may have been a material influence in locating the disease in the eyes.

I subsequently procured for the patient admission into the London Hospital under the care of Mr. Waren Tay, and he derived much benefit. I believe, however, that he relapsed soon after his return home. A portrait has been preserved in the collection of the Royal College of Surgeons.

DISEASES OF THE NERVOUS SYSTEM.

No. XIX.—*On the sensation of throat-grip in Ataxy.*

The girdle pain of locomotor ataxy is well known. It is, I think, always assigned to the chest, and I do not know whether any one has described what might be called the throat girdle, or sensation of strangulation, which is not very infrequently complained of in patients in an advanced stage of this disease. They describe it as being a very distressing sensation, beginning with a feeling as if it was necessary to swallow, but impossible to do so, and advancing to one as if the throat was gripped outside. There is also a feeling as if suffocation were impending, but never any real difficulty in drawing breath. The patients who suffer from it almost always imagine that there is some swelling of the glands. Other throat and nose symptoms are sometimes present in conjunction with it, such for instance as an irritable cough, or a tendency to sniff while talking. I have seen several patients who offered very marked examples of this throat girdle sensation. They have all been in advanced stages of the disease. A gentleman came to me the other day whom I have been attending for years for ataxy after syphilis, and who is now quite blind. He was in great alarm on account of an attack of throat sensation such as I have described. It has lasted during about twenty-four hours, and he described the sensation as having been very distressing. There was nothing whatever to be discovered in the throat.

No. XX.—*On the sensation of nose-grip in various forms of Neurasthenia.*

There is another symptom occasionally met with in the earlier stages of various nerve disorders, but especially in

ataxy, which patients compare to the feeling as if some one were gripping them across the nose. I see not a few patients with this symptom who come with the belief that there is some syphilitic disease of the bones of the nose. But there is nothing of that sort ever to be found. The sensation is always located in the bridge of the nose, and not in the tip, and it sometimes lasts for several weeks together. I have encountered it chiefly, as just suggested, in men who had at some previous time suffered from syphilis. In some it has proved to be a premonitory symptom of ataxy, but not, I think, by any means in all cases. In some it has seemed to be indicative only of defective nerve tone.

No. XXI.—*On some of the causes of vague symptoms of nerve disorder occurring in the lower extremities.*

In cases of failing power in the lower extremities or of abnormal sensations, we have constantly to ask two principal questions. They are these: First, are these symptoms due to syphilis? and, secondly, are they caused by any one of the modes of sexual excess? It is often exceedingly difficult to decide this point, and in not a few cases we have to come to the conclusion that both causes have been at work, and that in devising measures of treatment it will be wise to try to allot the respective shares rather than to refer the phenomena exclusively to one. The subjects in whom these difficulties occur are usually men, and in some cases they have had long treatment, and we often have to take into consideration the question whether the abuse of the iodide of potassium may have had a share in reducing the tone of the nervous system.

The case which I have now to relate, although very like many others, will, I think, place a certain part of this question in an unusually clear light.

Mr. H—— was sent home from South Australia on account of symptoms which threatened paraplegia. He brought to me a very excellent account of his case from his surgeon, whose name, for obvious reasons, I must not record. It appeared that Mr. H——, who was a bachelor of about 39 years of age, had been "feeling funny in his feet." He had experienced a

sense of formication in the feet, and a sensation as if cold wind were blowing over the feet and legs. He had also felt his legs weak, especially if he stood long; and once at a public meeting he had nearly fallen down. The same thing had subsequently happened whilst playing at billiards. Yet with this he was apparently a very powerful man. His reflexes were normal, and he had no ataxic pains. As there was a remote history of syphilis, his surgeon had prescribed the iodide in full doses, and sent him home to England. When he went on board the steamer he could only just manage to walk. During the voyage he took no medicine, and when he reached England and came to me he was all but well. The leg symptoms had vanished, and his only complaint was that he felt somewhat weak.

A fortnight after his arrival in London he came to me again, in a state of great despondency. His legs ached and felt so weak that he could scarcely stand, and the soles of his feet were constantly pricking. He compared the sensation rather to the constant fizzing of soda-water than to pins and needles. The feet felt asleep, and he could not bear to stand still a minute. With these sensations in the feet he had also, he said, a cold, sticky feeling in his hands, as if they were sweating, and he must wash them. Add to these local conditions, he said that he felt languid, unfit for exertion, and very unwilling to attend to business.

I should not have thought it worth while to describe these symptoms in so much detail, but that I think we may with great confidence assign them to their true cause. On returning to London, Mr. H—— had resumed relationships with an old mistress, and after a period of enforced celibacy on shipboard had been indulging very freely. He himself suggested to me this explanation quite spontaneously, but it was exactly what I had suspected before he spoke.

No. XXII.—*Paralysis of third nerve—Rapid and almost sudden recovery.*

A man (J—— J——) who was under my observation in August, 1878, presented a somewhat unusual combination of

conditions. His recovery was also exceptional in its rapidity. His right third nerve was almost completely paralyzed, but yet his pupil was not dilated. He had ptosis, and was unable to use any of the third nerve recti; nor could he effect accommodation. His two pupils were about No. 2 in size, both dilated a little when covered, perhaps to 3, and both contracted again when exposed. The left acted perhaps a little more rapidly than the other, but both were very slow and moved but very little. I inferred from this at the time that probably his vaso-motor nerve was defective in both eyes, and that this explained the non-dilatation of the right pupil.

The cause of the paralysis is not easily assigned. The man denied syphilis. He had married at twenty-two, had lost his first four children in infancy, but had five living. He appeared to speak candidly, and assured me that he was never in his life exposed to the risk of syphilis. Yet he said definitely that he felt much better after a week's treatment with iodide. His ptosis, &c., had been preceded by a week's headache, or rather pain over the affected eye. This pain was new to him, for he had previously always had good health. It was three weeks since the lid first drooped. He had double vision and giddiness if both eyes were open. He had had bad nights, and had slept in the daytime. There were no other symptoms of locomotor ataxy. He had no shooting pains, no stomach attacks, and he walked well with the eyes closed.

Six weeks after the above notes were taken I saw the patient again, and made the following note.

September 16, 1878. Ten days ago he suddenly found that he could lift the right upper-lid, and now there is scarcely a trace of ptosis, and the recti act well. It is remarkable how suddenly the improvement occurred. He says that one evening whilst at work he suddenly found that he could lift the lid and use both eyes together. He was taking potassium iodide, in five-grain doses. He feels quite well, and has no giddiness. He has regained perfect accommodation, and reads No. 2 at 10″ as well with right as with left.

No. XXIII.—*Paralysis of one third nerve, without history of cause—Rapid and permanent recovery.*

I well remember seeing, a great many years ago, a case which was similar to the above, in the fact that whilst all specific history was absent yet the iodide cured. It occurred in the person of a medical friend. He was a married man, of middle age, and assured me that he had never had syphilis. He had paralysis of one third nerve. There were no concomitant symptoms, and he was in good health. The eyelid drooped over the eye. I said, "Syphilis or no syphilis, I know of nothing but the iodide for you." We gave him it, and in a fortnight or less he was quite well. I then said jokingly, "Well of course it was not syphilitic, but I advise you whenever you ail anything in future to take iodide of potassium." He laughed, but still with seeming sincerity asserted that he had never had syphilis. I saw him repeatedly during several years afterwards, and am not aware that any recurrence ever took place.

No. XXIV.—*Partial Cycloplegia in both eyes—History of an attack of paralysis of the third nerve in one eye ten years ago—Syphilis possible.*

Mr. S——, aged 50, a pale gentleman, consulted me Jan. 20, 1874, for defect of sight. He could read No. 1 with R. with + 20, and also with the left with + 9; with both he could see $\frac{20}{20}$ with a little difficulty. The pupil of the left was nearly twice the size of the other and almost motionless, but it did alter a little on strong sudden exposure. The pupil of the right was smaller than natural, but moderately active. He had been, he told me, under Mr. Dixon ten years ago for from three to four months for a similar attack in the other eye, but with ptosis and diplopia (paralysis of third nerve). On that occasion he got quite well. The left eye had never failed until last Christmas. He had scarlet fever thirty years ago, which he thinks left his throat weak, and he had been a little deaf for many years. He admitted a sore on the penis eighteen years ago, which was treated for

three months, but he did not recollect any constitutional symptoms. He had been married fifteen years and had four healthy children (aged 14, 12, 10, and 7 respectively). Although there was no proof of constitutional syphilis or of sequelæ, yet the occurrence on two occasions of local nerve disease was very suspicious. I prescribed iodide of potassium, but have no information as to the result. It is very possible that this case may have since developed into one of locomotor ataxia. The case is of interest in respect to the long interval between the two attacks.

No. XXV.—*Permanent contraction of the fingers into the palms after a very severe and prolonged cerebral illness — Complete recovery in other respects.*

A very curious form of contraction of some of the fingers was presented in the case of a woman named C——, in whom it had been developed in connexion with severe disturbance of the nervous system. She was a married woman, of about 45 years of age, a patient of Dr. G——'s, of Southgate Road. Great family troubles had come upon her about four years ago, and apparently in consequence of them her nervous system gave way, and she became insane. She felt as if she could do nothing, could not move, and accordingly took to her bed. After that she became violent, but she remembers nothing further until ten months later. In the interval she had been under Dr. Marshall's care in Colney Hatch. Of this period her memory is a blank. When she was recovering, for a long time she feared that she should never regain her mental power, for she could not remember names nor the commonest facts.

When she was convalescent she found her hands bandaged, with corks in the palms to keep the fingers straight. It availed nothing, however, and her present condition is that the little, ring and middle fingers are firmly bent till the tips almost touch the palm. They are quite fixed, although not anchylosed. The tendons do not start materially. The index finger

bends forward a little, but not much, and the thumb is not affected.

She can do but little with her hands, but can just manage to feed herself and to write.

Mrs. C—— has now quite regained her health, and is lively and active. She says, however, that she is easily put out, and that when made nervous her eyesight often partially fails. She is liable to profuse perspirations at night. Her bowels, formerly costive, now act well.

The above notes were taken in November, 1874. They are, I think, of interest in reference to prognosis. It may easily be the fact that some of my medical friends, especially those engaged in the treatment of insanity, may be more familiar with contractions of the fingers from such causes than I am.

No. XXVI.—*A peculiar form of local eruption of Herpetic character directly following the use of Arsenic.*

That arsenic can cause herpes zoster in its most characteristic forms, I have not the least doubt. Sometimes, however, it produces eruptions which resemble herpes in being of transitory duration and disappearing spontaneously, but which never assume definitely vesicular features, or look in the least like ordinary zoster. Of this I think we have an instance in the following case.

I ordered Pearson's solution of arseniate of soda in three-minum doses three times a day for Mrs. S——, a lady of 40, who had psoriasis. She had as a consequence, a week after beginning the arsenic, aching pains in the skin of both thighs. She could not tell what it meant, but there came out an eruption of little red spots, which lasted about a week and then faded away, although she continued the medicine.

It is, I believe, mainly to this form of eruption that the name "arsenical eczema" used formerly to be given. It will be seen that in the above case this eruption was in both sides. This is exceptional, for the arsenical forms of herpes are seldom symmetrical. A late Master of the Rolls, who had suffered all his life from psoriasis, and had taken much arsenic, became

liable to an eruption just like that above described. It always came out if he took arsenic. In order to convince me, he took small doses for three days, and then came and showed me one arm covered by a large irregular patch of little red spots. They were intensely irritable, but did not assume herpetic characters. In him the eruption was on one limb only. It faded away very quickly when the drug was disused. I have often before mentioned his case, but it so closely corresponds with the above case that I am obliged to adduce it again. Both cases are, I think, very conclusive.

No. XXVII. — *Effect of Arsenic on the Nervous System.*

Miss H——, who on account of lupus erythematosus has taken much arsenic, is not now having it. She has had none for three months. "Do you know any difference in your state?" I asked. "Oh, yes! I have not the painful tingling in my hands and feet I used to have."

SYPHILIS.

No. XXIII.—*A case of Midwifery Syphilis with exceptional features—Insignificant chancre—High temperatures—Large Bubo threatening suppuration.*

Mr. E. J. H——'s case is of much interest as an illustration of exceptional conditions both in the primary sore and in the gland swelling. He was a medical student and engaged in assisting his father, when he had the misfortune to contract a sore on the side of one of his fingers. This sore never showed anything definite or materially suspicious. It was a slightly thickened patch, excoriated in the middle, and about as large as a fourpenny-piece. He thought nothing of it until the glands in his armpit began to swell. When he came to me he had a gland mass in the armpit as large as a small fist, which was glued to the inner border of the pectoral muscle, and obviously threatened suppuration. His temperatures every evening were from 102 to 103. As there were no secondary symptoms, I felt compelled to wait a little while before venturing to feel sure that we had to deal with an infecting sore, for the bubo was exactly like that which attends the soft sore. I carefully examined his skin and throat on three occasions with intervals of a week, and then thinking that there were a few lichenoid spots of a suspicious nature, though very insignificant, I advised him to begin mercury. During the next week a very characteristic rash came out, and he had ulcers in the tonsils.

The effect of the mercury in procuring the disappearance of the gland mass was very definite, but it is right to admit that it was beginning to subside before the specific was commenced. Mr. H—— came to me first on Sept. 30th, and he

then believed the sore on his finger to be six weeks old. The sore had never been painful. He commenced the use of mercury on Oct. 12th, but his temperatures had fallen to normal, and the threatening of suppuration was at an end before its use. The glands remained afterwards exceedingly hard.

Finally, under continued treatment by mercury, he made an excellent recovery.

I give this case for the consideration of those who think that it is always easily possible to recognize infecting sores, and that the buboes which attend them are always small, hard and bullet-like.

No. XXIV.—*Doubtful diagnosis of Syphilis as to whether a sore was primary or tertiary.*

The case of Captain U—— was of interest in reference to diagnosis. He came to me with a dusky erythematous eruption which covered large areas over the backs of his shoulders and upper arms. There were some spots also on his back and chest, none on the fronts of his arms. It was symmetrical, quite superficial, and according to his statement of nearly two months' duration. I certainly at first sight took it for a secondary rash, but it will be seen that it had not a quite characteristic arrangement. It was in large patches fairly well margined, and did not in the least approach a roseola. On proceeding to search for the chancre I found his genitals perfectly sound, and although he admitted exposure to risk about three months ago, he said that he had not had the slightest local irritation. At the lower part of the orifice of his left nostril, however, there was a deep ulcer with a clean surface and very hard edges. Its edges might have been taken for those of rodent, and its general characters were like those depicted in my atlas of illustrations (Plate). It occurred to me that this might be the primary sore, and I inquired carefully as to dates. At one time he said that the sore on the nose had come first, and at another that the rash and the sore appeared simultaneously. Captain U—— had just arrived from Mexico, and during the last two weeks he

had been taking mercury on shipboard. He was a married man and was returning to his wife. He had been exposed to risk with extreme rarity and had never contracted any disease, excepting once five years ago, when he had a soft chancre from which nothing followed. During the five years' interval he had had no reminders and no sort of treatment, having been in perfect health. There could be no doubt whatever that the ulcer in the nostril and the eruption were both specific, but the question was whether they were new disease, or whether they were a relapse of what he had five years ago. Against the idea of the sore in the nose being a primary chancre, was the fact that he had had no gland enlargement in the neck. It is, I think, very rare for any primary sore to occur on any part of the face without gland implication, although such a result is common enough in the case of chancres on the penis. Had the ulcer on the nose appeared alone, there would have been no difficulty in considering it tertiary ; but it was not easy to adopt this explanation when it was coincident with a secondary eruption. The result of treatment quickly confirmed the main diagnosis, for under mercury the ulcer quickly healed and the rash disappeared.

No. XXV.—*Sclerotic hypertrophy of lymphatic trunks above the corona glandis—Remote history of Syphilis.*

I have never seen the condition I am about to describe excepting in this and one other instance.

A gentleman of 45 is in anxiety about a little roll of induration just above the corona glandis. It is quite visible, and at first sight I took it for the remains of an indurated sore. On examination, however, I found that it quite encircled the penis and is exactly symmetrical, and that the mucous membrane of the reflected prepuce is not in the least adherent. It is a little sinuous, and exactly as if a piece of moderately thick whipcord had been put under the mucous membrane. It does not adhere to the deeper parts. It begins on each side close to the frœnum, and winds upwards to the middle of the dorsum. Just where the cords end, each passes upwards

for half an inch, thus causing what would have been a circle to present a Λ-shaped notch. My patient is a married man, in good health and with two healthy children, but he had syphilis twenty years ago and gonorrhœa four years ago. He has known of the condition described for four years, and believes that it followed the gonorrhœa. It has never given him the slightest inconvenience, but as it has recently got larger it has made him anxious. When he had his syphilis the chancre was in the frœnum, but there has not been any tendency to relapse of irritation in that part, nor has he for many years had any reminder of his syphilis.

I have no doubt that the cords described are indurated (sclerosed) lymphatic trunks, and should think it probable that the long bygone syphilis has caused the sclerosis. Probably these lymphatics were inflamed with the chancre, and that we have an instance of the setting up of chronic changes in structures which were long ago slightly damaged. The gonorrhœa was probably the exciting cause of the recurrence. It is of interest to note the extreme slowness with which the condition has advanced, and also that it is exactly symmetrical. As yet we cannot trace the trunks higher than the dorsal edge of the septum, and there is no enlargement of the inguinal glands.

No. XXVI.—*On Sclerosed lymphatic trunks in connection with Syphilis.*

In connexion with the above note it may be of interest to describe certain little subcutaneous knots which I have no doubt are familiar to all who see much of constitutional syphilis. They occur in various parts of the body, and especially I think on the arms, are seldom bigger than a pea or horse-bean, and never quite round. They usually feel very firm and nodular, as if a small hardened tube were twisted on itself. No lines of inflamed lymphatic trunks nor any implication of the glands attends them, and they are usually painless. They do not show any tendency to implicate the surrounding cellular tissue, or to cause spreading gummata. There are usually several of them in the same patient. I have always regarded them as sclerosed lymphatic trunks.

No. XXVII.—*Long persistence of a mottled erythematous eruption in secondary Syphilis, not treated by specifics.*

I scarcely know whether the term "dappled"* might be conveniently used in reference to certain erythematous conditions of the skin. Although etymologically it is said to be derived from "dabbing," and to mean "covered with spots," yet there is a marked difference between a dappled surface and a spotted one. The more you look at a dappled horse, the less are you able to resolve the condition into one of mere spots; the tints shade into each other very gradually, and are so arranged that the groundwork rather than the spots becomes conspicuous. The state of congestion in the skin of a corpse in which the colour is produced along the lines of small veins, and certain central areas are left pale, approaches pretty exactly to what I think dappling should mean. If I am correct, there is a condition of erythema of the skin, occuring under various conditions but particularly in the early ages of syphilis, which is exactly dappling.

A very good example of what I would call a dappled eruption occurred to me in a person who was sent to me by Mr. Coalbank, Teddington, for diagnosis. The whole of his chest and abdomen and fronts of his arms were congested, the congestion being arranged in such a manner as to inclose ill-defined paler spots, and to produce an appearance exactly similar to the skin some time after death, or to the dappling on a grey horse. There was not the slightest thickening of the skin, nor any approach to papules. The state came nearest to a roseola, but in reality there were no patches of redness or tufts of vessels, like those seen in measles. It was a dusky red surface with ill-defined paler spots on it. The diagnosis as to the cause of this condition was somewhat difficult. I should certainly have taken it for the first stage

* I find it difficult in dictionaries to distinguish between "dappled" and "mottled." The condition of "dappling," as I define it, is beautifully shown in portrait No. 68 of Neumann's Atlas of Skin Diseases, just published under the name "Leukoderma Syphiliticum."

of a syphilitic exanthem, and should have supposed that it had not been present more than a few days, and would soon give place to some other more definite form of eruption. The patient asserted, however, that it had been out for six weeks, and the evidence as to syphilis was doubtful. He had had an attack of gonorrhœa three months ago, and with it some very transitory excoriations. His frœnum had been torn. During the last fortnight he had had a slight sore throat. His throat, however, showed nothing but general congestion. The most suspicious fact was a very definite enlargement of his inguinal glands.

Jan. 28.—The rash has much faded in the fortnight, and has quite left his arms. There are superficial ulcers on the tonsils which are very suspicious. For these we order chlorate of potash, and still defer specifics.

Feb. 12.—As yet we have given no mercury, and it is just a month since the first note. The rash, although less definite, still remains, and is of just the same character that it was. It is a sort of mottled erythema, and occurs only on chest and abdomen. It might be easily overlooked or supposed to be only a normal condition. It is indeed only an exaggeration of the mottling often seen in healthy persons. It increases somewhat if he remains naked. His throat under chlorate of potash is better as regards ulceration, but the tonsils are still large and he complains that they feel stiff. The inguinal glands are enlarged and very hard on both sides. I now advise that mercury should be given, being convinced that we have to do with the secondary stage of syphilis.

No. XXVIII.—*Unusual and persisting eruption in the secondary stage of Syphilis.*

A patient whom I saw with Dr. Lichtenberg presented a very unusual form of eruption after syphilis which remarkably resisted treatment. He was a man of the age of 34. His sore was contracted on the 6th of September, 1887, and became indurated. In October he had roseola, and an eruption on his back, which Dr. Lichtenberg described as looking like vibices. In February the eruption was increased

and he had an ulcer on his velum. Inunction of mercury was now substituted for a mixed mercury and iodide treatment which he had had before. During the summer of 1888 he was in Berlin and had sore throat on and off, and his eruption, in spite of treatment, still persisted. On October the 10th, that is one year after the commencement of the eruption, he was sent to me, the reason for the consultation being that the eruption still remained out. He had been salivated to a slight extent, and was so when he came to me. The eruption was very peculiar; it occurred chiefly on his shoulders and upper part of back, but to a slight extent also on his chest and thighs. It was in long oval patches and streaks, of a dusky brown tint, and gave him exactly the appearance as if he had been flogged. Some of the patches were polished and crinkly. We gave him more mercury with iodide in combination, but a month later his condition was almost the same, as will be seen by the following note. After this the three iodides were given together in still larger dose, and in combination with the bichloride. During the whole of this period he had no other symptoms whatever, and was in excellent health.

Nov. 27.—The stains are still present in long coffee-brown streaks on his back, and in patches more or less rounded on his arms, fore-arms and thighs. He says that they are not new, but relapses of the original ones. New ones, he says, come and go: those in the back persist. The newer ones are slightly scaly and rough; those on his back are becoming slightly polished. They itch a little. They are arranged much like the brown streaks in Leprosy as shown in Danielsen and Boeck's atlas, or their portrait of "Psoriasis." He is in excellent health, and has no other syphilitic symptoms. He has taken mercury freely, and kept the mouth a little sore. He says that a few applications of the ointment easily remove the spots for a time.

On May 13th, 1889, he again presented himself. He considered himself quite well excepting the stains, and during the last months no fresh spots had appeared. None of the patches were at this date in the least scaly. Although much less conspicuous than formerly, they were still easily seen.

The following note was taken: "The patches are now only glossy stains. He takes Turkish baths, which remove the epidermis from the intervening skin, and leave the stains the more conspicuous. The latter are brownish, and quite smooth and glossy in their surfaces (like the true Lichen-Ruber). They are easily distinguished on looking obliquely over the back, by their shining surfaces. They are in streaks and ovals, and his back and shoulders look as if he had been flogged."

MISCELLANEOUS NOTES.

No. I.—*Typhoid Fever not fatal in children.*

It is a very remarkable fact for the student of the exanthemata that typhus fever is scarcely ever fatal in children. Dr. Grimshaw, in his evidence before the Vaccination Commission, said, "I never saw a young child die of typhus fever, and I have seen thousands of cases."

No. II.—*Swelling of the Face from Copaiba.*

A gentleman who had been taking oil of sandal-wood capsules for two weeks without ill effects, changed them for copaiba, with the result that his face and eyelids swelled up directly, "as if I had erysipelas." It declined quickly when the drug was left off, but the conjunctivæ remained watery. He had no eruption on the body.

No. III.—*Result of Amputation of whole hand, with the exception of the thumb.*

A navvy, aged about 50, had his left hand amputated (leaving carpal bones) four years ago. When I examined his hand the thumb had good movements and strength. He said, however, that he would rather be without his thumb, as it caught against things in his shovelling work when he had his artificial hook-hand on. On the whole he decidedly considered that the thumb was in his way. With better mechanism and in other employments it might perhaps have been made more useful, but as it was he did not consider conservative surgery a benefit.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. XXIX.—*On Reproduction.*

1. Define the terms "gamo-genetic" and "agamo-genetic."
2. What is meant by conjugation in a biological sense?
3. Is the impregnation of the ovum effected by the entrance of a single spermatozoon, or of several?
4. What is meant by the term "spermatogenesis"?
5. What is the process which in the female corresponds with spermatogenesis in the male named?
6. What are the chief phenomena of ovulation?

ANSWERS.

1. Gamo-genetic (=sexual reproduction) refers to impregnation and the results of admixture of protoplasm from two distinct sources or individuals. Agamo-genetic (=a-sexual reproduction) is applied to multiplication of individuals from a single parent, without marriage or sexual admixture. It has been well called "simply discontinuous growth."

2. It is the simplest form of sexual generation, and consists in the coalescence of two similar masses of protoplasmic matter derived from different parts of the same organism, or from two organisms of the same species.

3. It is believed that as a rule, with very few exceptions, only a single spermatozoon enters the ovum. If two or more force their passage, the result is probably a monstrous development.

4. The production, by the testis, of the male element or semen. The essential constituents of semen are the spermatozoa. The function of spermatogenesis is not taken up until

the animal has attained a certain age; it varies much at different periods of life and under different circumstances, and diminishes in activity as age advances. Its commencement is marked by important changes in the whole organism, which are denoted in their aggregate by the term puberty.

5. It is called ovulation. Puberty in the female is the period at which *ovulation* commences, and it is usually denoted by the occurrence of menstruation.

6. Congestion and growth take place in certain parts of the ovary (follicles or ovum-capsules), and as a result the ovum ripens and is expelled. Its expulsion is attended by intense congestion and hæmorrhage (menstruation). After expulsion, the cavity, which contains blood-clot, contracts, and a "corpus luteum" results.

No. XXX.—*On Generation and Impregnation.*

1. Distinguish between generation and impregnation.

2. How are drones, working bees, and queen bees respectively produced, and in what do they differ?

3. Can the workers (females in suppression) ever produce eggs?

ANSWERS.

1. Generation is effected whenever a new individual organism is produced, and may be wholly independent of impregnation. In the words of Huxley, "Generation may be regarded as a particular case of cell-multiplication, and impregnation simply as one of the many conditions which may determine or affect that process." Or again, impregnation is the physical admixture of protoplasmic matter derived from two sources, which may be either different parts of the same organism, or of different organisms.

2. The drones are male bees, and are produced from eggs which have not been impregnated; the workers are females, and are from impregnated eggs; the queen is a worker whose development has been increased and specialized by the liberal supply of a particular kind of food. Drones never show any tendency to collect honey; workers collect honey, but produce no eggs; the queens do not collect, but produce eggs. It is

a mistake to call the workers "neuters," for their sex is only suppressed, and they are undoubtedly females.

3. Yes; occasionally a worker is fertile and may lay eggs. They are, however, never susceptible of impregnation; and their eggs produce only drones.

No. XXXI.—*On Fractures near the neck of Humerus.*

1. When the neck of the humerus is broken in elderly persons, what is the usual position of the fracture?

2. Distinguish between the surgical neck, the anatomical neck, and the line of the epiphysis respectively.

3. What may we infer from the conditions met with in such fractures in old persons?

4. What is the usual displacement in such cases?

ANSWERS.

1. The line of fracture is often oblique, or in parts spiral. Thus it may come close to the head behind, and be low in the surgical neck in front. It is often attended with comminution, and it is very rarely cleanly transverse.

2. The surgical neck is that part of the bone well below the tuberosities, where it is narrowed down to little more than the size of the shaft. The anatomical neck may be marked by a line drawn round the bone, close below its articular head. The line of junction of the epiphysis is between these, and would leave the two tuberosities still attached to the head.

3. The line of breakage being irregular in its course, and not keeping either to the anatomical or surgical neck, its occurrence indicates that the bone has undergone some senile atrophy and become somewhat brittle. In a younger and stronger bone the same kind of violence would probably have produced a dislocation, or a more near approach to a transverse fracture. At any age under puberty the lesion produced would probably be a detachment of epiphysis.

4. The displacement is often but slight. Its chief feature is a drawing towards the chest of the upper end of the lower fragment.

No. XXXII.—*On Amputations of the Foot.*

1. What is a Chopart's amputation?
2. What are the supposed disadvantages of a Chopart's stump?
3. For what cases is a Chopart applicable? What is the usual alternative?
4. In what does a "Syme" differ from a "Pirogoff"?
5. What cases are suited for Syme's amputation?
6. What points require special attention in the performance of a "Syme"?
7. What are the objections to a "Pirogoff," and what its advantages?

ANSWERS.

1. Removal of the foot, leaving only the os calcis and astragalus.
2. It takes away the front support of the arch of the instep, and it is often followed by retraction of the heel.
4. In Syme the whole foot is removed at the ankle, whereas in Pirogoff the posterior third of the os calcis is left, and turned up into apposition with the tibia.
5. All cases of disease or injury of the foot, or of the ankle joint, in which the heel is uninjured.
6. Care must be taken not to cut the posterior tibial too high, and also not to jag or score the heel flap.
7. A Pirogoff, in addition to the risk that the part of the os calcis which is left may be displaced backwards, makes, even in the best cases, a stump which is too long to be convenient.

No. XXXIII.—*On Gall-stones and Obstruction of the Bowels.*

1. In what way may gall-stones simulate obstruction of the bowels, and in what way may they really produce it?
2. Are cases of hepatic colic always attended by jaundice?
3. How would you treat a case in which you had diagnosed a gall-stone in the cystic or hepatic duct?
4. How would you treat a case in which you diagnosed a gall-stone impacted in the bowel?

5. Is it possible for a large stone, say as thick as one's thumb, to escape from the gall-bladder without ulceration?

ANSWERS.

1. A gall-stone impacted in the cystic or common duct may, by the pain and sickness caused, simulate acute obstruction, and the more easily because temporary constipation always attends the attack. A gall-stone which has passed the ducts may, if very large, become impacted in the intestine and produce real obstruction.

2. No; if the stone be in the cystic duct, no jaundice will occur. If in the common duct, the production of jaundice will still be a question of time, and the symptoms must not be expected in recent or short cases.

3. The indications are to relieve spasm and pain, and thus favour the passage of the stone. Probably the use of anæsthetics to full insensibility is the most hopeful measure. Afterwards morphia may be given, or the anæsthetic may be long continued or repeated at intervals if the pain persists.

4. If a stone be impacted in the bowel anæsthetics should be used, and large enemata should be given (in the hope that the fluid may pass the ilio-cæcal valve).

5. Yes; the duct is capable of great dilatation, and may allow very large stones to pass with but little suffering.

No. XXXIV.—*On Hernia.*

1. What forms of hernia are often present at birth or in infancy?

2. To what forms of hernia is the female sex most liable?

3. What is the commonest form of hernia in men?

4. How would you distinguish a congenital from a non-congenital hernia (of the inguinal form)?

5. How would you distinguish between a femoral and an inguinal hernia in a case of difficulty?

6. State the anatomical differences between a direct and oblique inguinal hernia?

7. By what rule do you hope to avoid hæmorrhage in dividing the stricture of an inguinal hernia? By what in the case of femoral?

8. What is the cause of risk of bleeding in a femoral hernia?

ANSWERS.

1. Inguinal in male children; umbilical in those of both sexes.

2. Femoral and umbilical.

3. Oblique inguinal, but femoral is also not infrequent.

4. By the position of the testis in relation to the contents of the sac. It is concealed behind and amongst the contents in congenital; pushed down to the bottom of scrotum in non-congenital.

5. By passing the finger up the cord, and ascertaining whether or not the inguinal canal was free.

6. A direct hernia passes through the external ring, tearing or stretching the conjoined tendon, whilst an oblique passes through the inner ring in front of the tendon. A direct hernia has the epigastric vessels on its outer side, and an indirect on its inner side.

7. By cutting directly upwards, and as cautiously as possible. By dividing as little as possible, preferring to make several small notches rather than one free one.

8. If the obturator artery is given off from the external iliac or epigastric, it may curve directly over the neck of the sac.

No. XXXV.—*Fracture of Patella.*

Describe the appearances presented in the woodcut.

1. Can you infer anything as to the probable nature of the accident?

2. Is bony union of a fractured patella frequent?

3. On what circumstances does the prospect of bony union chiefly depend?

ANSWERS.

1. The specimen shows complete bony union of a transverse fracture of the patella. The fragments are of nearly equal size. On one side a small portion has been detached, a feature which suggests that probably the fracture was not one due solely to muscular violence. [History not known.] Probably a blow was received when the knee was bent and the bone fixed. Hence it is mainly a "transverse" but in part a "starred" fracture. Probably there was never much separation of the fragments.

2. Bony union is the rule in all starred fractures, and it is not uncommon in those caused by muscular contraction.

3. The wide separation of the fragments in the first instance, and the amount of subsequent effusion into the joint, are the chief influences in preventing bony union.

No. XXXVI.—*Ankylostomiasis.*

1. What is the nature of the disease known as Ankylostomiasis, or Tropical Chlorosis?

2. Who was its discoverer, and in what countries has this worm been identified?

3. Is the disease of interest to British practitioners?

4. What proportion of the Egyptian population is supposed to suffer? What other names has the disease received?

5. What is the possible source of the parasite?

ANSWERS.

1. The disease resulting from the presence of the ankylostomum duodenale in the intestine of man. The symptoms are those of anæmia with rapid œdema, which may end fatally, or, on the other hand, may clear up quickly. The worm is a næmatoid, and probably gains access to the body in foul water. A number of worms are found attached to

the mucous membrane of the duodenum, the place of each being marked by a lenticular ecchymosis.

2. Dubini of Milan was its discoverer. He found it in five per cent. of his autopsies. It was very fatal to the workmen in the St. Gothard Tunnel, and has been found in Egypt, in Ireland, and many other places. Dr. Kynsey believes that what is called Beriberi in Ceylon is identical with Ankylostomiasis. Dr. Beaven Rake has found it in two autopsies at the Leper Hospital, Trinidad.

3. It is very possible that unrecognized cases occur occasionally in English practice.

4. Egyptian Chlorosis, or Tropical Chlorosis, are other names for the same disease. The worm is said to be present in one-fourth of the whole population in Egypt.

5. It may be a development of the Dochmius Trigonocephalus of the dog.

No. XXXVII.—*Destruction of one Kidney.*

The above woodcut shows the bladder, kidneys and spleen of a dog.

Explain the conditions.

ANSWER.

The bladder contains two calculi of considerable size. The left ureter is much dilated, and the left kidney is converted into a cyst. The other kidney is healthy. No doubt the calculi had originated in the left kidney and travelled down its ureter, causing the destruction of the organ and dilation of the ureter. The bladder is thickened.

COMMENTS.

The specimen is of interest as illustrating one of the conditions under which single kidney may be produced. So far as excretion of urea was concerned, the animal was clearly dependent solely upon the right kidney. Had the ureter of this organ chanced to become blocked by a calculus, death from uræmic poisoning would have ensued.

Calculi are rare in the lower animals.

No. XXXVIII. — *On the use of the term "Catarrhal."*

1. To what class of maladies ought the term "catarrhal" to be restricted?

2. What is their mode of origin?

3. Are all inflammations of mucus surfaces attended by discharge properly called "catarrhal"?

4. Are catarrhal affections contagious?

5. Are the domestic animals liable to catarrh?

6. Do catarrhal affections observe stages?

ANSWERS.

1. To those of which an ordinary "cold in the head" or "sore throat from catching cold" are the types.

2. They are produced by reflex disturbance of function and nutrition through the nervous system. Thus wet feet may cause sore throat, or a draught of cold air on the back may induce inflammation of the Schneiderian membrane.

3. When such maladies as chronic cystitis, or metritis, or otitis, are called "catarrhal," a good word is worse than wasted in misapplication. Such maladies are of a wholly different nature from the true catarrhs, and are due to wholly different causes.

4. It is highly probable, or perhaps certain, that the products of a catarrhal inflammation may become the means of communicating the like disease by contagion to others.

5. Most of our domestic animals appear to be very liable to catarrhal affections. Their catarrhs are probably communicable to the human subject.

6. All true catarrhs being of neurotic origin, observe stages and show a tendency to subside spontaneously after a certain duration.

No. XXXIX.—*On Catarrhal Affections.*

1. Are there exceptions to the statement that all true catarrhal affections tend to subside spontaneously?

2. Does one attack of catarrh in any degree prevent another?

3. What catarrhal affections are dangerous to life?

4. What other catarrhal affections may we recognize apart from those of the nose and throat?

5. What are the principles of treatment in catarrhal affections?

[See ARCHIVES, Vol. I. p. 307.]

ANSWERS.

1. All catarrhal affections show a tendency to spontaneous cure after a week or ten days. In some exceptional cases, however, recovery is not completed, and the disease may lapse into a chronic form.

2. One attack undoubtedly gives protection for a time, but the periods of immunity vary very much and may be exceedingly short. During the early stages of convalescence there is often great susceptibility, and unless the causes are avoided, relapses may easily occur.

3. Catarrhal pneumonia and catarrhal laryngitis are very dangerous affections unless properly treated.

4. We recognize catarrhal pleurisy, peritonitis, enteritis, &c. Probably all the viscera and all the serous cavities may be affected through the reflex influence of cold. Certain forms of rheumatism are probably catarrhal synovitis.

5. The indications are, to restore, as promptly as possible,

the disturbed balance of the nervous system (primary), and of the circulation (secondary). Warmth to the whole surface, heat to the feet, scrupulous exemption from exposure, are the chief indications. Diaphoretics and stimulants which tend to relax the peripheral arteries (alcohol, &c.) should be given. There are a great number of popular methods of cure based on these indications.

No. XL.—*On Catarrhal Affections.*

1. What is the distinction between coryza and catarrh?

2. Does constitutional disturbance attend a true catarrh?

3. Ought we to distinguish between an inflammation induced by the direct influence of exposure to cold and a true catarrh?

4. Give instances of inflammations due to direct exposure of the part to cold.

5. Are the phenomena of true catarrh always symmetrical?

6. Are there any apparent exceptions to the law of bilateral symmetry in catarrhal affections?

ANSWERS.

1. The term "coryza" is applicable to the symptoms of Schneiderian inflammation (sneezing, mucous discharge, &c.) which attend catarrh when the head is affected. Coryza is the name for the commonest symptom of true catarrh, the latter the name for the whole illness.

2. Yes, invariably. A catarrh is a brief nervous fever preceded by a rigor and attended by increase of temperatures, great sense of chilliness, and much general discomfort.

3. Yes, a true catarrh is always due to reflex disturbance, and never to any cause of irritation applied directly.

4. Exposure to cold wind may induce otitis or ophthalmia. Affections so produced are usually on one side only; they may cause constitutional disturbance, but are not preceded by it. They show no tendency to observe stages or to subside spontaneously. Chilblains and frost-bites are examples of inflammations due to direct exposure to cold.

5. The phenomena of true catarrh are always symmetrical, *i.e.*, bilateral.

6. In the case of double organs such as the lungs and kidneys, one may be much more severely affected than the other, and the disease may thus appear to be onesided.

No. XLI.—*Lactation and Conception.*

1. In the human subject does lactation always prevent conception?

2. What evidence do we obtain on this point from observations on the domestic animals?

3. By what measures has it been sought to prolong milk-giving in cows?

4. In spite of the facts above mentioned, is there still reason to believe that prolonged lactation in women has on the whole a tendency to prevent conception?

ANSWERS.

1. It is quite certain that lactation does not prevent fecundation. Many women become pregnant whilst suckling. Dr. Robertson, Dr. Laycock, and others, have collected statistics proving the frequency of this.

2. A rabbit may be impregnated within a few days of delivery. Farmers expect their cows to bear a calf a year and to give milk eight months. Under this arrangement, pregnancy must commence nearly six months before lactation ceases.

3. The attempt has been made, by the removal of the ovaries soon after parturition, to convert the cow into a milk-giving animal only, and thus secure an indefinite prolongation of the lactation period. Sufficient success has, I believe, attended the experiments to warrant the belief that ovarian activity is the chief agent in arresting mammary secretion. There is, however, great risk of spoiling a good cow and obtaining only a partial result.

4. It is a well-established fact that in the human subject lactation, as a rule, prevents menstruation. This gives strong support to the general belief amongst women that it also tends to prevent conception.

No. XLII.—*Case for Diagnosis.*

The following is a contemporary abstract given in the *Medico-Chirurgical Review* of 1843 :—

"M. Huguier relates a case of that rare occurrence, *spontaneous gangrene of the surface* in a child, aged 7½ years. The previous history of the patient was unknown, beyond his own statement, that two months before he had had a very violent cold. When received into the Charité, the tips of all the fingers of the left hand were black, and those of the right hand had begun to show a darkish colour. All the toes of the left foot were quite black, the middle toe had dropped off, and the tips of the toes of the right foot were also black. There was neither pain nor redness in the course of the arteries, nor were they less yielding and elastic than natural. The child was bled twice, and took opium during his stay in the hospital; the duration of which, as well as many other points of importance in the case, are not stated. He left the hospital well, having lost all the toes of both feet, the fingers of the left hand, and the whole of the right hand, as also the skin at the tip of the nose, at the prominence of the cheek-bones, the chin, and the edges of the ears." ("Clinique des Hôpitaux des Enfants," December, 1842.)

1. Is the expression "spontaneous gangrene of the surface" a correct description?
2. What name would now be applied to the disease described?
3. How is it to be distinguished from frost-bite?
4. What are its causes?

ANSWERS.

1. No; for it is not proved to have been spontaneous, and was probably not so; and it certainly was of the extremities as contrasted with the surface. The chin, the tip of nose and the ears, must all be classed as "extremities."

2. The case is one of Symmetrical Gangrene of the Extremities, or Asphyxia of the Extremities, now often spoken of as Raynaud's disease.

3. As an example of Raynaud's disease it is of uncommon severity, and it is to be diagnosed from frost-bite chiefly by

the absence of exposure to extreme cold and of any preceding stage at all approaching to congelation. The parts affected are precisely those which might have suffered in frost-bite. No doubt it was a case of what might be called "cold-bite" in a very susceptible individual.

4. The causes of Raynaud's symptoms are augmented reflex susceptibility of the arterial system to the influence of cold. This may be in part a congenital peculiarity. It may have been developed or increased by the influence of malaria, by undue exposure to cold or other depressant; by some severe illness. In the above instance it is probable that a delicate underfed child had, after a severe catarrhal illness, been very inadequately protected from the prolonged influence of cold (not actual frost).

No. XLIII.—*Osteitis Deformans.*

1. Distinguish between Osteitis deformans (Paget's disease) and Arthritis deformans.
2. What are the most prominent features of Osteitis deformans?
3. What are the conditions of its pathological anatomy?
4. Are other structures than the bones ever affected?
5. Has it any connection with syphilis or gout or cancer?
6. What is the prognosis?
7. At what age does it occur?

ANSWERS.

1. They are wholly different maladies. The one is a joint disease, a form of chronic rheumatism; the other, a very peculiar affection of the osseous system, having probably no association with arthritic maladies.

2. The patient loses stature owing to softening and bending of his bones generally, and his head enlarges so that he needs larger hats. His skull and long bones are found to be enlarged in a more or less even or fusiform manner.

3. On dissection, the bones are found to be enlarged by great overgrowth of a soft porous structure. On the long bones there is more or less appearance of encrustation, but this is not usually very definite. The enlargements are

usually on both sides of the body and in all limbs, but they are rarely quite symmetrical.

4. The patients sometimes become more or less deaf and blind. In the eye, choroiditis may be found.

5. It has no connection with syphilis, and probably none with acquired gout. Its subjects often die of cancer.

6. It is a disease of extremely slow progress, and is attended by but little failure of general health.

7. The disease never begins in the young, and usually not till past middle life.

No. XLIV.—*Essential Phthisis Bulbi.*

1. What is meant by the term "Essential phthisis bulbi"?
2. Describe its features.
3. What are its supposed causes?
4. Are its conditions constant, or variable?

ANSWERS.

1. This quaint term, which might perhaps be suitably translated "primary softening of the eyeball," was applied by Von Graefe to certain rare cases in which, without obvious cause, the tension of the eye becomes suddenly and greatly reduced.

2. No pathological change is to be detected (as is the case in the numerous cases in which "phthisis bulbi" is secondary to inflammation). The eyeball becomes more or less squared by the pressure of the recti, and the cornea a little hazy by wrinkling of the membrane of Descemet. Neuralgic pains are usual. The tension may be suddenly recovered and then again suddenly fail. There may be opacities in the vitreous. Very few cases are on record, and some of these not quite characteristic.

3. It has chiefly been noticed after injuries near to the eye or operations upon it.

4. It scarcely deserves to rank as a disease, and is probably always a symptom of disease of the vitreous, or of replacement of part of it by serous fluid capable of rapid changes in amount. Its phenomena are, however, worthy of very careful examination.

[Consult "Archiv f. Ophth." xii. 2, p. 256; *Dublin Quarterly Journal of Medical Science* (Swanzy), vol. xlviii. p. 531.]

PLATE XXII.

DESQUAMATIVE DERMATITIS CURED BY OPIUM.

The patient from whose left hand this drawing was made was a woman aged sixty-one, fairly developed, and (apart from the eruption) in excellent health. Both hands and feet, the scalp, the groins, the corners of the mouth, and the canthi of the eyelids were affected by a chronic exfoliative dermatitis, which had commenced nine months before, in the form of red spots between the fingers, and three months later had attacked the toes. No cause could be assigned, and there was no history of skin-diseases in the family. Her tongue was very clean and red, almost "beefy." Both hands and feet were attacked in a precisely symmetrical manner; on the latter all the toes were affected, but the disease did not extend much above them. All the nails were inflamed and rough. The disease tended to spread from the digits upwards. On the backs of the wrists and on the neck there were a few small detached patches, and these were increasing in number; they also showed a strong tendency to advance at their edges. They were for the most part quite dry, were attended by peeling of the epidermis and by some slight swelling, and tended to form fissures. When the scales were removed by applications the surface left was smooth, raw-looking, and red. The scalp was everywhere involved, and the hair very thin. There were symmetrical patches at the corners of the mouth, which were gradually extending, with abrupt margins, on to the cheeks. The inner commissures of the eyelids were also affected, and there were symmetrical patches on the groins.

The patient had undergone much skilled treatment before I saw her; arsenic had been freely used, and, amongst other measures, she had been salivated. A complete cure finally resulted under the use of opium. The hair grew again, the nails were completely restored, and the skin of the hands became soft and healthy. I do not think that there could be the least doubt as to the opium being really the cause of the recovery. It was continued for upwards of three months. The dose was from five to fifteen minims of the Liquor Opii Sedativus. The patient regained good health, and remained well several months after the opium was disused. Six months later there was a slight tendency to relapse, but she again recovered.

PLATE XXIII.

ERYTHEMA-URTICARIA FROM VEST-IRRITATION.

It might, perhaps, be useful if a classified arrangement of the causes of skin disorders were attempted, in addition to endeavours to group the diseases themselves. There are certain eruptions to which the term "Vest-Eruption" is more practically appropriate than any which should attempt to designate the character of the rash itself. They come in consequence of the irritation of the vest, and usually of a flannel vest. Sometimes it is the case that the patient has recently adopted some new material, or changed from his thin summer garment to a thicker one for winter. Vest-rashes are usually limited to the parts touched by the vest, but they are by no means always the same in character. Sometimes they show a tendency to spread to other adjacent parts.

In the portrait is shown the chest of an adult man, who had been working hard in very hot weather with a woollen vest on. He had perspired very freely indeed, but had not dared to put aside his vest for fear of catching cold. The result was a profuse erythematous-urticaria over all parts where the vest touched. The eruption, as shown, was in margined patches raised at their borders, of a bright red tint, whilst their centres were pale and depressed. It differed from a true urticaria in the persistence of the individual patches, and its limitation to the parts which had been irritated. It soon got well on removal of the cause. In other cases, vest-eruptions may present features very different from those here shown. An excellent Portrait, in 'Wilson's Atlas,' shows a lichenoid eruption, exactly limited to the vest regions. No doubt it was of the causation above described.

Vest-eruptions form an important group of the class of "Skin diseases due to the irritation of clothing."

PLATE XXV.

FIG. 1.—CANCER OF THE MALE BREAST.

FIG. 2.—CANCER OF BREAST, WITH CYSTS AND ADENOID GROWTH.

THE upper figure shows the section of the breast of an old man with a mass of scirrhus in the centre. The nipple is deeply retracted, and by its side is a small cyst-cavity containing greenish fluid. The scirrhus mass is very dense, pale and fibrous-looking. It puckers-in the surrounding fat, and apparently involves almost the whole gland.

The patient was an old gentleman of seventy-four, who had known of the tumour for six months before its removal (Feb. 15th, 1870). I believe that he remained well after its excision, and had no recurrence.

The lower figure shows the section of the breast of Mrs. C., aged fifty-four, in whom scirrhus was developed, together with cystic and adenoid disease. She had had a sore nipple for two years, but had noticed a tumour only eight months. To the left is seen a congeries of cysts, which contained blood-stained fluid and soft endogenous growths. Above the cysts is a circumscribed mass of adenoid growth, and to the right of the latter the structures are puckered by infiltrating scirrhus.

The illustration is of value as enforcing the desirability of excision of the whole breast in all cases of cystic disease in which induration remains after evacuation of the cyst-contents. It may perhaps be said that in all cases in which the cyst-contents are blood-stained, or other than perfectly clear, excision ought to be done. In this instance a large quantity of cyst-fluid had been evacuated by tapping some weeks before the operation.